



Considering Ethnic Diversity in Clinical Supervision and Clinical Practice

Ayesha Roche

Submitted for the award of

Doctor of Clinical Psychology at The University of Sheffield

May 2017

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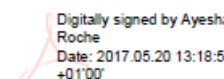
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Excluding references	7,938
Including references	9,972
Including references and appendices	10,352

Research Report

Excluding references	11,469
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Abstract

The United Kingdom (UK) is becoming increasingly diverse, highlighting the need for mental health services to respond adequately to the communities they serve. Previous research highlights ethnic inequalities occurring across a range of mental health services, including psychological services. This suggests that services and practitioners may not be recognising and responding adequately to the culturally informed needs of individuals.

The first part of the thesis reports a systematic literature review exploring the impact of culturally competent clinical supervision on psychological practitioners in training. Results found evidence to suggest that highlighting and discussing cultural issues in supervision can positively impact the supervisory relationship and supervisee's satisfaction with supervision. There is preliminary evidence that culturally competent supervision can also positively influence supervisee practice.

The second part of the thesis aimed to identify the nature of ethnic inequalities occurring within psychological services in the UK, using routinely collected data. The study aimed to explore ethnic differences occurring at service intake, across therapy outcomes, and across therapy processes. The results found evidence of significant ethnic inequalities occurring at each stage examined. Patients from ethnic minority backgrounds presented to services with significantly higher levels of psychological distress and subsequently had poorer psychological outcomes following therapy. Patients from ethnic minority groups were also more likely to be perceived as having a poorer quality of engagement in therapy.

Together the two studies highlight the need to consistently monitor and address ethnic inequalities in psychological services and to systematically ensure cultural competence development is prioritised throughout practitioner training programmes.

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Section One: Literature Review

A Systematic Literature Review Exploring the Impact of Culturally Competent Clinical
Supervision on Psychological Practitioners in Training

Abstract

Objective. To review the evidence regarding the impact of culturally competent supervision on psychological practitioners in training. The review aimed to identify the areas of impact which highlight if, and how, culturally competent supervision is important.

Method. Systematic searches were conducted of databases (PsycInfo, PsycArticles, Medline and Web of Science) and of relevant reference lists. Studies were included if they aimed to explore the impact of culturally competent supervision, and the definition of cultural competence involved attending to ethnic diversity.

Results. Fifteen studies met the inclusion criteria, two were subsequently excluded due to poor quality. Thirteen studies were included in the full content review ($N = 1,541$). The studies explored the impact of culturally competent supervision on four areas of impact; the supervisory relationship, satisfaction with supervision, supervisee self-efficacy, and clinical practice. Positive and significant relationships between culturally competent supervision, the supervisory relationship, and satisfaction with supervision were consistently found. Qualitative studies also highlighted the negative impact of culturally unresponsive supervision. The results regarding the impact of culturally competent supervision on self-efficacy and clinical practice were mixed. The qualitative evidence suggested that addressing cultural issues in supervision, on a case by case basis, can directly influence supervisee practice.

Conclusions. The findings suggest that demonstrating cultural competence in supervision can have a positive impact; the extent to which this impact extends to supervisee self-efficacy and clinical practice is unclear. The review also highlighted considerable methodological weaknesses in this area, demonstrating the need for further research.

Practitioner Points

- Addressing cultural issues in supervision in a responsive and sensitive manner is likely to have a positive impact on the supervisory relationship.
- Supervisors should attend to cultural issues in relation to clients discussed in supervision, as this may influence the delivery of culturally responsive therapy.
- Addressing issues around ethnic diversity inappropriately in supervision can have a negative impact on supervisees. Practitioners should consult the available literature and access to training to guide culturally competent supervisory behaviour.

Limitations

- The qualitative papers reviewed were all cross-sectional studies, therefore, conclusions of causality cannot be made.
- None of the included studies were based in the United Kingdom, limiting the generalisability of the findings.
- The grey literature was not extensively searched, increasing the possibility that the results of the review may be limited by publication bias.

Cultural competence refers to the demonstration of awareness and skill, in relation to understanding and working with the multiple dimensions of identity a person may hold (Suki & Melliush, 2013). The current review is concerned with the dimensions of identity and experience influenced by ethnicity. Cultural competence in the context of supervision extends to the active process of using the supervisory relationship to consider how aspects of diversity may, explicitly and implicitly, effect therapeutic and supervisory interactions (Falender, Shafranske & Falicov, 2014).

Supervision is a fundamental aspect of training programs for psychologists counsellors and therapists; to ensure effective and ethical client care, and to support the development of the supervisee (Dooley & Peyton-Lander, 2014). Attending to cultural issues within supervision should ensure the provision of culturally responsive client care and facilitate the development of the supervisee's cultural competence (Falender et al., 2014; Falender & Shfranske, 2007; Ryde, 2011). However, there is yet to be a review of the evidence in this area.

Clarification of Terms

The term ethnicity is used in reference to groups characterized by a common nationality, culture or language (Betancourt & Lopez, 1993). Culture refers to a common set of group practices and beliefs that inform and are informed by social norms, roles and values. Within this definition it is acknowledged that all people are influenced by, and belong to a culture (Traindis et al., 1980). The terms trainee and supervisee will be used to refer to individuals enrolled in training programmes, involving clinical supervision, for the purpose of qualifying as psychological practitioners (psychologists, therapists or counsellors).

Cultural Competence in Supervision

Cultural competence in psychological practice is defined across three core dimensions; awareness, knowledge and skills (Sue, Arredondo and McDavis, 1992). Awareness refers to a conscious appreciation of one's own cultural heritage, its influence on beliefs, attitudes and practices, and awareness of differences between self and other. Knowledge refers to an understanding of how culture can impact on perceptions of normality and distress and appreciating the impact of racism, oppression, and discrimination. Skill refers to culturally informed therapeutic approaches adopted by clinicians to respond appropriately to culturally informed needs and expressions (Sue et al., 1992). This framework for cultural competence was developed for therapeutic work with clients, however, it has since been applied to the delivery of culturally competent supervision (D'Andrea & Daniels, 1997; Ortega-Villalobos, 2003).

Supervisors demonstrate cultural competence in supervision through highlighting, conceptualising and working with cultural issues which arise in the context of the supervisory relationship, and between the supervisee and client. (Ortega-Villalobos, 2003; Sue et al., 1992). Falander and colleagues (2014) described culturally competent supervision as follows;

Awareness, knowledge and appreciation of three-way interaction of the client's, the supervisee's and supervisor's values, assumptions, biases, and expectations derived from worldviews, and integration of practise, assessment and intervention skills (Falander et al., 2014).

Despite clear frameworks for the provision of culturally competent supervision, little is known about the extent to which it is applied in practice, or the impact it has (Gurpinar-Morgan, 2012).

The Impact of Culturally Competent Supervision and Practice

A common assumption of cultural competence models, is that developing awareness of cultural issues and integrating these into practice will improve some aspect of outcomes for individuals from ethnic minority backgrounds (Gurpinar-Morgan, 2012). This is important due to the diverse nature of the UK's population and the continued inequalities within the mental health system that have persisted for decades (for a review see; Grey, Sewell, Shapiro, & Ashraf 2013).

There is an emerging body of evidence which suggests that individual and organisational efforts to provide culturally competent care can improve outcomes for individuals from black and minority ethnic groups (Beach et al., 2005; Bhui et al., 2015; Lo & Fung, 2003; Truong, Paradies & Priest, 2014). Despite this evidence, research also suggests that cultural issues are not routinely discussed in supervision (Gatmon et al., 2001; Shah; 2010). Some practitioners express reluctance to address issues around ethnic diversity, due to feelings of discomfort, or fear of causing offence (Crossley & Salter, 2005; Maxie, Arnold & Stephenson, 2006; McKenzie-Mavinga, 2009).

Despite the rhetoric around cultural competence and the outlined commitment of professions to work effectively and inclusively around issues of diversity, these conversations continue to be difficult to have, particularly in the public forum of training environments (Ellis & Cooper, 2013; Nolte & Nell, 2012). Supervision may be a potentially powerful place to discuss issues of cultural diversity due to the combination of intimacy and containment the supervisory relationship can represent (Harrell, 2014). Ideally, this would result in supervisees feeling able to discuss issues around culture, ethnicity and difference across a wider range of forums (Constantine, 1997; Falender et al., 2014;).

Improving the cultural competence of clinicians is not only important for client outcomes, but also for supervisee personal and professional development (Sehgal et al., 2011). Psychological professions place considerable emphasis on processes of self-reflection and the integration of the personal and professional self (British Psychological Society, 2010; Hughes & Youngson, 2009). It is recognised that supervision plays an important role in facilitating these processes (Patel, 2000; Ryde, 2011). Research into the experience of trainee clinical psychologists from Black and Minority Ethnic (BME) backgrounds has highlighted that professional identity development can be a particular challenge for BME trainees. Immersion into a largely white profession led by Eurocentric norms and values can cause difficult feelings, from discomfort to rage (Paulraj, 2016; Shah, 2010). This difficulty is exacerbated for BME trainees who encounter colleagues and supervisors who fail to provide a safe space for conversations around ethnicity, resulting in experiences of feeling marginalised and silenced (Aditemole et al., 2005; McNeil, 2010; Shah, 2010).

Aims of the Review

Frameworks of culturally competent supervision presume that attending issues of ethnic diversity in supervision in a skilful manner will result in positive outcomes for supervisees and their clinical practice. There are a growing number of studies that have attempted to empirically or qualitatively measure the impact of culturally competent supervision, yet there is no known review of these studies to date. The current review aims to understand if the existing research supports the notion that culturally competent supervision is important. This aim will be achieved through systematically reviewing relevant literature to identify the impact culturally competent supervision has on psychological practitioners in training.

Method

Search and Selection Strategy

A systematic literature search was conducted between December 2016 and February 2017. Four databases were searched; PsycINFO, PsycARTICLES, MEDLINE and Web of Science. The Boolean operator “AND” was used to combine variations of the following search terms; (i) “culture* competenc*”, “cultur* responsiv*”, “cultur* humility” (ii) “professional supervision”, “practicum supervision”, supervision (iii) psychotherap*, “clinical psychology”, psychologist*, counsell*, therapist. The references of full text articles assessed for eligibility were also searched to identify any further relevant papers for inclusion.

Inclusion Criteria

The following inclusion criteria was determined to identify relevant papers:

- Research aims are focused on the impact of culturally competent supervision
- The definition of culture and/or cultural competence refers to working with ethnic diversity
- The provision of supervision is related to practice based clinical work with children, adults or families

Papers were excluded on the following basis: (1) Research focusing on culturally competent supervision processes rather than outcomes (2) Primary research aims did not concern the impact of culturally competent supervision (3) Research concerned with the cultural characteristics of supervisors (e.g. ethnicity/race) rather than supervisor cultural competence. (4) Studies concerning cultural issues arising in group supervision (5) Studies comparing cultural competence across supervision in different countries (6) Studies focused on specific cultural variables, other than ethnicity, and (7) Papers focused on theoretical frameworks of culturally competent supervision.

Figure 1 provides an illustration of the screening and selection process completed following the literature search. A total of 553 papers were initially identified through database searches. The screening of paper titles resulted in the exclusion of 459 papers. The abstracts of the remaining 94 papers were screened and a further 57 papers were excluded as they did not meet the inclusion criteria. Thirty-six full text articles were further scrutinised for eligibility with 11 meeting the criteria for inclusion. The specific reasons for exclusion are presented in Figure 1. In addition, four papers were identified through searching the references of the full text papers reviewed. A total of 15 papers were included at this stage of the review.

Quality Assessment

The 15 studies that met the inclusion criteria were quality assessed utilising the QualSyst checklists (Kmet, Lee, & Cook, 2004). The QualSyst assessment guidelines recommend the exclusion of papers obtaining a quality score below .75 as this indicates poor quality. Based on this criterion, two papers were excluded from the full content review. Details of the methodology and quality scores for all of the studies are presented in Table 1. Studies are set out in chronological order.

In accordance with the QualSyst tools (Kmet et al., 2004), the quantitative studies were rated using 14 assessment criteria (see Appendix A). Two points are allocated where criteria were fully met and one point for criteria partially met. If a criterion is not applicable to the study, the points for that item are omitted from the total number of points available. The quality rating is calculated by adding the total number of points awarded and dividing this score by the total number of points available.

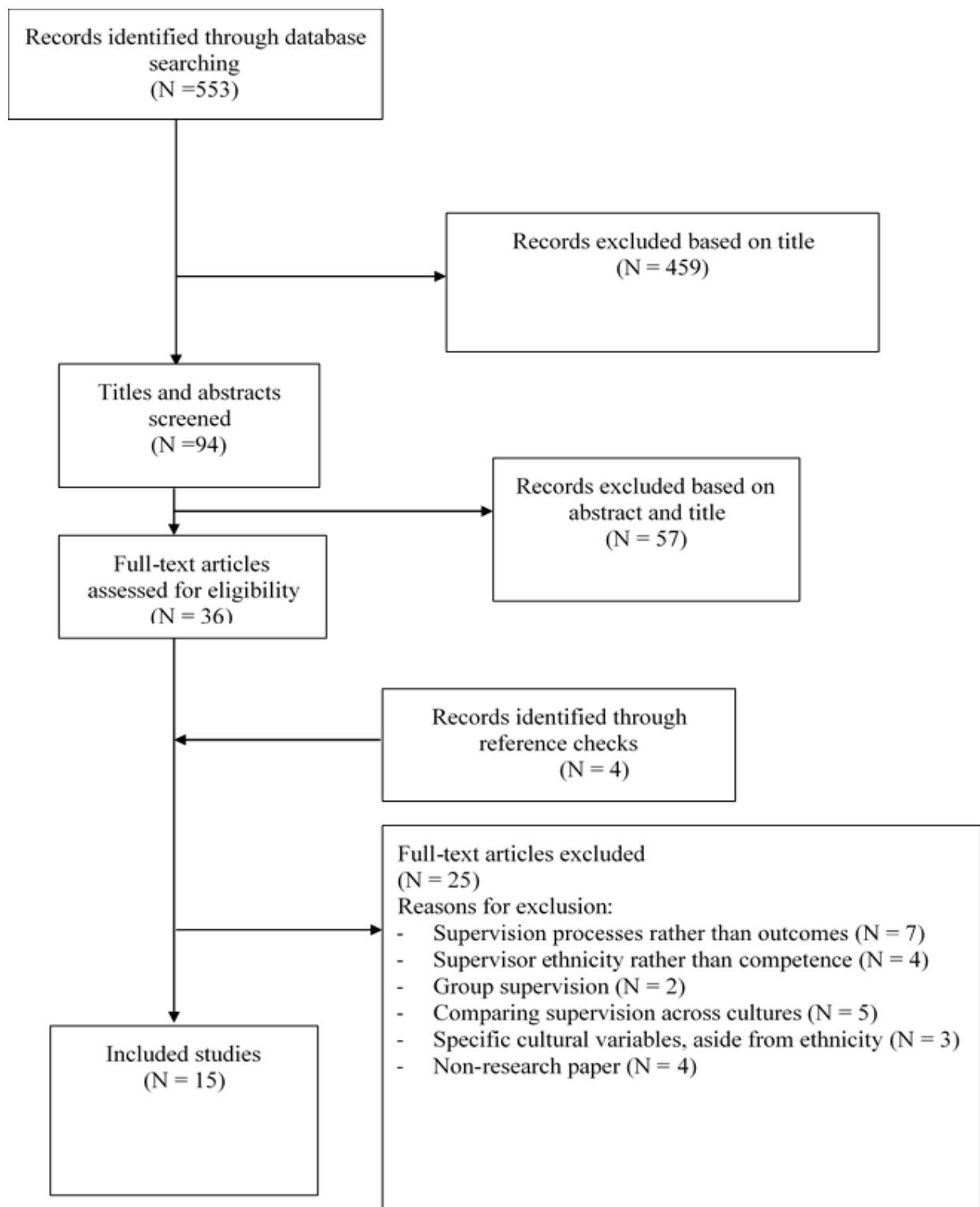


Figure 1. Details of the screening and selection process

Qualitative studies were rated using 10 assessment criteria (Appendix B). All ten of the criteria are deemed applicable to qualitative methodology and therefore there is no option to omit criteria based on non-applicability. Otherwise, the scoring system is the same as that applied to quantitative studies.

To verify the quality ratings, three papers were randomly selected to be independently rated by a second assessor, a trainee clinical psychologist in the final year of completing a Doctorate in Clinical Psychology. Inter-rater reliability scores indicated good inter-rater reliability ($Kappa = .76, p = .001$; Peat, 2002), discrepancies in scoring were discussed until agreement was reached. See Appendix C for study quality ratings.

Results

The methods, quality ratings and key findings of all fifteen papers are presented in Tables 1 and 2. Two studies are omitted from the full summary of research findings due to low quality ratings (Breux III, 2005; Diggles, 2013). Across the 13 studies included in the full review a total of 1,370 (mean = 152.22, range = 71 - 289) participants took part in quantitative research studies and 171 (mean = 42.75, range = 15 - 102) participants took part in qualitative studies. Twelve studies took place in the USA and one in Australia.

Two studies recruited international students from a range of continents and countries; South Asia, China, Japan, Hong Kong, Europe, Canada, Mexico and Arabia. The remaining studies recruited an average of 30.09 (24.23%) participants from BME backgrounds, identifying with the following ethnicities; African American, Asian American, Hispanic and Arabic. Various methods were used across the studies to assess culturally competent supervision (see Table 1 for details of the specific measures used).

Table 1.

Characteristics of Reviewed Studies

Authors (year), country	Study aims	Design and sample	Measures	Quality rating	Included
Gatmon et al. (2001), USA	To explore the relationship between culture-based discussions in supervision and supervisee satisfaction and working alliance.	Cross- sectional design 289 pre-doctoral professional psychology interns	<ul style="list-style-type: none"> • The Working Alliance Inventory (Horvath & Greenberg, 1989) • The Supervision Questionnaire-Revised (Worthington & Roehlke, 1979) • Researcher developed measure of culture-based discussions 	.77	Yes
Toporek et al. (2004), USA	An exploration of how critical incidents, relating to cultural issues, in supervision impact supervisee cultural competence development.	Qualitative research design 17 masters-level trainee counsellors and 11 counselling supervisors.	<ul style="list-style-type: none"> • Multicultural Supervision Critical Incidents Questionnaire (researcher developed). 	.80	Yes
Breaux III (2005), USA	Examining the relationship between supervision satisfaction, and supervisor cultural competence	Cross-sectional design 61 counselling supervisor-supervisee dyads	<ul style="list-style-type: none"> • Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition– Revised (MAKSS-CE-R; Kim, Cartwright, Asay, & D’Andrea, 2003) • Supervisory Satisfaction Questionnaire (SSQ; Ladany, Hill, Corbett, & Nutt, 1996). 	.73	No

Authors (year), country	Study aims	Design and sample	Measures	Quality rating	Included
Inman (2006), USA	To examine direct and indirect relationships between perceived supervisor multicultural competence, supervisory working alliance, trainee cultural competence, and supervision satisfaction.	Cross-sectional design 147 trainee marriage and family therapist (masters, postgrad and doctoral level)	<ul style="list-style-type: none"> • Supervisor Multicultural Competence Inventory (SMCI; Inman, 2005) • The Working Alliance—Trainee Version (WAI—T; Bahrack, 1990) • SSQ (Ladany et al., 1996) • multicultural case conceptualisation test (researcher designed) 	.90	Yes
Burkard et al. (2006), USA	To explore experiences of culturally responsive and unresponsive events in supervision. To examine and compare the perspectives of supervisees from BME and non-BME backgrounds.	Qualitative design 26 Doctoral students in professional psychology training programmes.	<ul style="list-style-type: none"> • Semi-structured interview protocol 	.95	Yes
Vereen et al. (2008), USA	Investigating aspects of training that influence trainee counsellors' cultural competence; clinical supervision, teaching experiences and exposure to non-white clients	Cross sectional design 198 masters and doctoral level trainee counsellors	<ul style="list-style-type: none"> • Multicultural Awareness-Knowledge-Skills Survey (MAKSSI D'Andrea, Daniels & Heck, 1991). • Survey questions regarding clinical supervision, training courses and exposure to working with non-white clients. 	.77	Yes

Authors (year), country	Study aims	Design and sample	Measures	Quality rating	Included
McLeod (2009), USA	To explore the experience of attending to cultural issues in supervision, from supervisee and supervisor perspectives.	Qualitative Supervision dyads, 9 trainee counsellors, 6 supervisors	<ul style="list-style-type: none"> • Semi-structured interview 	.95	Yes
Mori et al. (2009), USA	To explore the relationship between international trainees' acculturation level, cultural discussions in supervision, perceived supervisor multicultural competence and supervision satisfaction.	Cross sectional 104 international trainee psychologists/therapists/social workers	<ul style="list-style-type: none"> • Acculturation: American-International Relations Scale (AIRS; Sodowsky & Plake, 1991). • International Student Supervision Scale-Multicultural Discussion (ISSS-MD; Nilsson & Dodds, 2006). • SMCI (Inman, 2006) • SSQ (Ladany et al., 1996). 	.77	Yes
Ng & Smith (2012), USA	To investigate the relationship between international student's level of acculturation, supervisory working alliance, self-efficacy, role ambiguity, and multicultural discussions in supervision.	Correlational study design 71 international students training in counselling and related professions	<ul style="list-style-type: none"> • Counseling Self-Efficacy (COSE) Larson et al. (1992): • AIRS (Sodowsky et al. 1991); • Role Conflict and Role Ambiguity Inventory (RCRAI; Olk & Friedlander, 1992) • International Student Supervision Scale (ISSS; Nilsson & Dodds, 2006) • Working Alliance Inventory-Supervisee Form (WAI-S; Baker, 1990) 	.86	Yes

Authors (year), country	Study aims	Design and sample	Measures	Quality rating	Included
Diggles (2013), USA	A quantitative examination of the relationship between racial competency related coursework and supervision and trainee's racial awareness. The study also explored other student factors which may impact this; race, clinical experience and experience with racism.	Correlational study design 78 Couples and Family Therapist students at masters and doctoral level.	<ul style="list-style-type: none"> • Blind Racial Attitudes Survey (CoBRAS; Neville et al., 2000). • Racism Experiences-Frequency (EXP-TP; Harrell, 2000). • 3 item survey measuring exposure to racially competence coursework • 2 item survey measuring exposure to racially competent supervision. 	.72	No
Lee and Khawaja (2013), Australia	To identify aspects of training that are related to the cultural competence of trainee clinical psychologists'	Cross-section research design 127 postgraduate clinical psychologist students	<ul style="list-style-type: none"> • Multicultural Mental Health Awareness Scale (Khawaja, Gomez & Turner, 2009); • A survey regarding; multicultural training experiences, multicultural courses, clinical work with culturally diverse clients, and multicultural discussions in supervision 	.82	Yes
Soheilian et al. (2014), USA	To qualitatively explore the impact of integrating cultural issues into supervision on supervisee practise.	Qualitative design 102 supervisees on masters and doctoral programs of professional psychology	<ul style="list-style-type: none"> • Open ended questionnaire 	.90	Yes

Authors (year), country	Study aims	Design and sample	Measures	Quality rating	Included
Crockett& Hays (2015), USA	To explore direct and indirect relationships among supervisor multicultural competence, supervisory working alliance, supervisee counselling self-efficacy, and supervisee satisfaction with supervision.	Cross sectional study 221 graduate student members of the American counselling association	<ul style="list-style-type: none"> • The SMCI (Inman, 2005) • Working Alliance Inventory–Short Form (WAI-SF; Ladany, Mori, & Mehr,2007) • COSE (Larson et al., 1992), • Trainee Personal Reaction Scale– Revised (TPRS-R; Ladany et al.,1992) 	.91	Yes
Howell (2016), USA	To investigate the relationship between supervisor multicultural competence and the supervisory working alliance, from perspective of the supervisor.	81 community counsellor supervisors	<ul style="list-style-type: none"> • Multicultural Counseling Inventory (Sodowsky et al., 1994) • Supervisory Working Alliance Inventory-Supervisor version (Efstation, Patton & Kardash, 1990) 	.77	
Phillips et al. (2016), USA	To explore relationships between the depth of multicultural discussions, supervisory working alliance, self-efficacy, role ambiguity and role conflict in supervision. To examine the impact of belonging to a minority ethnic group on the relationship between these variables.	132 doctoral students training in clinical and counselling psychology	<ul style="list-style-type: none"> • Supervisory Working Alliance Inventory-Trainee Form (SWAI-TF; Efstation et al.,1990) • RCRAI (Olk & Friedlander, 1992) • Counsellor Activity Self-Efficacy Scale-Helping Skills Subscale (CASES-HS; Lent, Hill,& Hoffman, 2003) • Multicultural Self-Efficacy – Racial Diversity – Multicultural Intervention subscale (MCSE-RD; Sheu & Lent, 2007); • A researcher designed tool to assess depth of multicultural discussion 	.82	Yes

Four studies used standardised measures of supervisor cultural competence (Crockett & Hays, 2016; Howell, 2006; Inman, 2006; Vareen, Hill & McNeal, 2008). The two studies focusing on international students used the International Student Supervision Scale (ISSS; Nilsson & Dodds, 2006) which has a subscale measuring the occurrence of culture-based discussion, pertinent to international student status (Mori, Inman & Caskie, 2009; Ng & Smith, 2012). Three studies measured culturally competent supervision by quantifying the frequency or quality of culture-based discussion in supervision (Gatmon et al. 2001; Ng & Smith, 2012; Phillips, Parent, Dozier & Jackson, 2014). The qualitative studies used semi-structured interviews and open-ended questionnaires to elicit descriptive data concerning the impact of culturally competent supervision (Burkard et al., 2006; Howell, 2006; McLeod, 2009; Torporek et al., 2004) .

Quality of Studies

The quality of papers included in the full review ranged from moderate (.75) to high (.95), the quality of studies did not significantly improve over time $r_s = .07, p = .85$. The qualitative studies were given quality ratings ranging from .80 (Torporek et al., 2004) to .95 (Burkard, 2006; McLeod, 2009). Qualitative papers awarded higher ratings were characterised by several features; researcher reflexivity, detailed systematic data analysis, conclusions made with clear links to the data, and recognition of the study's limitations. The quality ratings for quantitative papers ranged from .77 (Gatmon et al., 2001; Howell, 2006; Mori et al., 2009; Vereen et al., 2008) to .91 (Crockett & Hays, 2016). Stronger quantitative studies were characterised by the following features; robust research designs, clearly presented findings; representative subject selection, standardised outcome measures, consideration of confounding variables, and conclusions grounded in the quantitative results.

Table 2.
Key Findings from Reviewed Studies

Authors and year	Study population	Relevant findings
Gatmon et al. (2001)	Pre-doctoral psychology interns	<ul style="list-style-type: none"> • Supervisees who reported discussing ethnic diversity reported significantly higher levels of working alliance. • No relationship was found between culture-based discussions and satisfaction with supervision. • Significant correlations were found between working alliance and the quality (depth, safety and satisfaction) of culture based discussions.
Toporek, Ortega-Vilaalobos & Pope-Davus (2004)	Supervisors and supervisees	<ul style="list-style-type: none"> • Critical incidents influenced development of supervisee cultural competence through various processes; increased awareness/ insight, development of culturally appropriate approaches and transparent communication with clients. • Critical incidents which had a negative impact were also described; conversation resulting in conflict/misunderstanding, lack of supervisor intervention and attention.
Breaux III (2005)	Supervisor-supervisee dyads	<ul style="list-style-type: none"> • No significant relationship found between supervisor cultural competence and supervisee satisfaction. • Individual cultural differences across supervisee-supervisor dyads did not significantly change the relationship between supervisor cultural competence and supervisee satisfaction.
Inman (2006)	Marriage and family therapist trainees	<ul style="list-style-type: none"> • Significant relationship found between supervisor cultural competence and trainee rated working alliance and supervision satisfaction. • Supervisory working alliance identified as a mediator in the relationship between supervisor multicultural competence and supervision satisfaction. • Supervisor multicultural competence was not significantly related to trainee's culturally competent case conceptualisation ability.

Authors and year	Study population	Relevant findings
Burkard et al. (2006)	Professional psychology doctoral students from White and BME backgrounds.	<ul style="list-style-type: none"> • Culturally responsive events had a positive impact on supervisee; increased cultural competence, increased satisfaction with supervision, and triggered a positive emotional response. • BME supervisees uniquely referred to feeling personally validated by the responsive discussion of cultural issues, and sometimes felt challenged/uncomfortable • Culturally unresponsive events had a negative impact on supervisees; changed supervisory relationship and increased anxiety and uncertainty around supervision • Differences found regarding the impact of both responsive and unresponsive events on non-white and white supervisees; emotional valence of reactions and perceived impact on clinical practise.
Vereen et al. (2008)	Masters and doctoral level trainee counsellors	<ul style="list-style-type: none"> • The combination of multicultural training classes, number of BME clients and cultural discussion in supervision did not have a main effect on supervisee multicultural competence. • Combination of having cultural discussions in supervision and a higher number of BME clients was significantly associated with higher levels of cultural competence in trainees. • There was no main significant relationship between cultural discussions in supervision or multicultural training classes on supervisee cultural competence. • Higher numbers of BME clients was significantly associated with higher levels of cultural competence.
McLeod (2009)	Counselling supervisors and their supervisees	<ul style="list-style-type: none"> • Positive and negative experiences of attending to cultural issue in supervision were described from the perspective of both supervisors and supervisees. • Positive experiences were experienced as enhancing the supervisory relationship, increasing self and other awareness, and led to the development of culturally competent formulation and interventions skills. • Negative experiences were described as resulting in feelings of anxiety and uncertainty, supervisee withdrawal, and feeling devalued.

Authors and year	Study population	Relevant findings
Mori et al. (2009)	International students on counselling, psychology, therapist and social work training courses	<ul style="list-style-type: none"> • Results showed that increased involvement in culture-based discussions significantly predicted higher levels of satisfaction with supervision. • It was unexpectedly found that supervisees less acculturated to USA culture reported significantly higher levels of satisfaction with supervision. • A significant direct relationship was found between perceived higher levels of supervisor cultural competence and increased satisfaction with supervision. • Mediation analysis suggested that involvement in cultural discussions may, in part, mediate the relationship between supervisor cultural competence and supervision satisfaction.
Ng & Smith (2012)	71 international students on counselling and professional psychology programs	<ul style="list-style-type: none"> • Culture-based discussions significantly positively correlated with supervisory working alliance and negatively correlated with role ambiguity in bivariate analyses. • Regression analysis revealed that multicultural discussion did not significantly predict supervisory working alliance when other supervision variables (role ambiguity) were included in the regression model. • Supervision variables, multicultural discussions and working alliance, did not significantly predict counselling self-efficacy. • Two aspects of acculturation (perceived prejudice and English language use) significantly predicted working alliance and counselling self-efficacy.
Diggles (2013)	Student therapist	<ul style="list-style-type: none"> • The frequency of supervision experiences related to racial competency was not significantly associated with student levels of racial awareness. • Students at a later stage of training had significantly higher levels of racial awareness. • Being non-white and having a higher number of personal experiences with racism was also associated with higher levels of racial awareness.
Lee & Khawaja (2013)	Clinical psychologists in training	<ul style="list-style-type: none"> • Number of hours students had spent discussing cultural diversity in supervision and working with culturally diverse clients significantly predicted higher levels of cultural competence. • Number of hours spent engaging in cultural awareness lectures and tutorials did not significantly predict trainee cultural mental health awareness.

Authors and year	Study population	Relevant findings
Soheilian et al., 2014	Professional Psychology trainees	<ul style="list-style-type: none"> • Culturally competent discussions in supervision were defined as follows; exploration of issue, culture-specific education, intervention modification and facilitated self-reflection and challenge. • Culturally competent discussion had a positive impact on trainee practise; improved supervisee awareness of cultural issues, increased discussions around culture with client, enhanced culturally informed formulation and interventions, increased empathy for client, and increased self-awareness/reflection.
Crockett & Hays, 2015	Trainee counselling students	<ul style="list-style-type: none"> • Supervisor cultural competence had a significant, direct and positive relationship with working alliance. • Supervisory working alliance had a significant positive association with supervisee satisfaction. • Supervisor cultural competence was not significantly related to supervisee satisfaction or supervisee self-efficacy. • Supervisory Working alliance partially mediated relationship between cultural competence and supervisee satisfaction.
Howell (2016)	Licensed counsellor supervisors	<ul style="list-style-type: none"> • Significant positive correlation between scores of supervisor cultural competence and scores of supervisory working alliance. • A hierarchical regression analysis found that higher levels of supervisor cultural competence significantly predicted higher levels of working alliance.
Phillips et al., (2016)	Students on training courses for counselling and clinical psychology	<ul style="list-style-type: none"> • A path analysis found that deeper discussions around race and ethnicity were associated with lower role ambiguity and greater working alliance. Depth of discussions around race were not significantly associated with self-efficacy. • Results did not significantly differ depending upon the ethnicity of the trainee.

Note. BME = black and minority ethnic

To address the aims of this review, the results are presented in relation to the areas of impact the findings relate to. Studies measuring the relationship between culturally competent supervision and more than one area of impact are discussed across more than one section.

The Impact of Culturally Competent Supervision on The Supervisory Relationship

The impact of culturally competent supervision on the supervisory relationship was explored across six quantitative studies (Crockett & Hays, 2015; Gatmon et al., 2001; Howell, 2016; Inman, 2006; Ng & Smith, 2012; Phillips et al., 2016) and two qualitative studies. All of the quantitative studies used standardised measures of supervisory working alliance to measure the supervisory relationship. Supervisory working alliance measures three factors thought to define a successful and functional supervisee-supervisor relationship; goal agreement, task agreement, and emotional bond. In addition, Gatmon et al. (2001) and Phillips et al. (2016) incorporated a measure of role ambiguity in the supervisory relationship. Role ambiguity refers to a lack of clarity regarding a supervisor's expectations and methods of appraisal (Olk & Friedlander, 1992).

Gatmon et al. (2001) found that supervisees who reported engaging in higher quality discussions around ethnic diversity also indicated they had a better working alliance with their supervisors. Discussion quality was measured by frequency, depth, perceived safety and satisfaction. Phillips et al. (2016) found similar results, but, with the use of more stringent methods of data analysis. Phillips and colleagues (2016) focused on the depth of culture-based discussions in supervision. Discussions described as “in-depth” were those which involved supervisee reflexivity, self and/or supervisor disclosure and supervisee shifts in perspective. The authors found that greater depth of culture-based discussions was associated with greater working alliance, whilst

controlling for demographic factors, level of training and completion of multicultural courses.

Burkard et al. (2006) qualitatively explored perceptions of culturally responsive and unresponsive events in supervision from the perspective of supervisees with ethnically different supervisors. The results suggested that culturally responsive events occurred in the context of a positive supervisory relationship and enhanced the relationship by increasing feelings of trust, safety and comfort. This also led supervisees to feel permitted to discuss issues around race and culture with their supervisor further. These findings are replicated within McLeod's (2009) qualitative study, which includes the perspective of six supervisors. The themes identified suggest that culturally competent supervision can empower supervisees to take risks in supervision due to increased feelings of safety and security.

The qualitative studies also highlighted the consequences of culturally unresponsive supervision. Culturally unresponsive incidences were described as avoiding, minimising, denying or overemphasising the importance of culture, race or ethnicity in any given situation (Burkard et al., 2006). In addition, culturally unresponsive supervisors were also described as being judgemental, critical or offensive toward supervisees who emphasised the importance of culture or race (McLeod, 2009). Culturally unresponsive actions were found to have a negative impact on the supervisory relationship. Supervisees described withdrawing from, and investing less in, the supervisory relationship due to fears of being judged or criticised, or misunderstood (McLeod, 2009). Supervisees also lost trust in their supervisors, resulting in less supervisee disclosure and feelings of discomfort within the supervisory relationship (Burkard et al., 2006). BME supervisees described stronger personal and emotional reactions to supervisors' lack of cultural responsiveness, in comparison to White trainees. This may have had a more enduring negative effect on the supervisory

relationship (Burkard et al., 2006). However, this is not reflected within the quantitative evidence as Phillips et al. (2016) found that trainee ethnicity did not significantly impact on the relationship between culturally competent supervision and supervisory working alliance.

Ng and Smith (2012) found that culture-based discussions in supervision sessions with international students did not significantly predict working alliance when role ambiguity was controlled for. However, within the Phillips et al. (2016) study the quality and frequency of culture-based discussions were significantly associated with better working alliance, whilst controlling for role ambiguity. This study had a larger sample and did not solely recruit international students, which may explain the difference in findings between the two studies. Levels of role ambiguity were higher in the sample of international students which may have influenced the results. Phillips et al. (2016) concluded that lower levels of role ambiguity reflect a supervisory relationship made up of clear communication and a sense of safety. This quality of relationship is likely to facilitate in-depth discussions around ethnicity and culture (Phillips et al., 2016).

Inman (2006) found a significant relationship between higher levels of supervisor cultural competence and higher scores of working alliance. This was corroborated by Crockett and Hays (2015) who tested a mediation model including measures of supervisor cultural competence, working alliance, supervision satisfaction and trainee self-efficacy. Increased supervisor cultural competence was associated with increased working alliance. Howell (2016) also found that supervisor self-reported levels of cultural competency were significantly associated with supervisor ratings of working alliance with their supervisees. All three papers concluded with summarising the importance of supervisor cultural competence on the development of a strong supervisory working alliance.

The Impact of Culturally Competent Supervision on Supervisee Satisfaction

In the current context, satisfaction with supervision refers to perceived quality of supervision based on the supervisor's personal approach, competence, and the supervisee's level of comfort with expressing personal and professional ideas and experiences (Holloway & Wampold, 1984). Five of the reviewed studies explored the relationship between culturally competent supervision and satisfaction with supervision (Burkard et al., 2006; Crocket & Hays, 2015; Gatmon et al., 2001; Inman, 2006; Mori, Inman & Caskia, 2009).

Gatmon et al. (2001) found that culture-based discussions in supervision did not have a significant main effect on satisfaction with supervision. However, correlational analyses found that the frequency, depth, safety and satisfaction scores for culture-based conversation, significantly and positively correlated with overall satisfaction with supervision. The safety of culture-based conversations had the relatively strongest correlation (moderate) with increased satisfaction.

Inman (2006) found a significant and direct relationship between higher ratings of supervisor cultural competence and higher ratings of supervisee satisfaction. Supervisory working alliance was also found to be a significant mediator between supervisor cultural competence and supervision satisfaction. These findings suggest that the relationship between supervisor cultural competence and supervisee satisfaction is influenced by working alliance. Crocket and Hays (2015) partly replicated this finding as supervisory working alliance played a mediator role in the relationship between supervisor cultural competence and trainee satisfaction levels. However, they did not establish a significant direct relationship between culturally competent supervision and supervisee satisfaction. Both papers concluded that culturally competent supervisors are likely to influence supervision satisfaction through

culturally competent supervision and developing a positive and productive relationship (Crocket & Hays, 2015; Inman, 2006).

Mori et al. (2009) explored relationships between supervisor cultural competence, culture-based discussions in supervision, supervisees' levels of acculturation and supervision satisfaction. Acculturation is described as the process of integrating new cultural knowledge and experiences whilst simultaneously preserving one's native culture (Sodowsky & Plake, 1991). Mori et al. (2009) found that the degree of involvement in culture-based discussions and scores of supervisor multicultural competence, significantly predicted supervisee satisfaction. Additionally, lower levels of acculturation to American culture were associated with higher levels of supervision satisfaction. This finding may mean that international students require different approaches to supervision based on their level of acculturation to the host country. It should be noted that acculturation is a complex process simplified somewhat crudely by the acculturation measure utilised (Matsudaira, 2006). This limits the extent to which conclusions can be drawn about how acculturation level of international students interacts with supervision processes and outcomes.

Burkard et al. (2009) found that all participating trainees indicated that their satisfaction with supervision increased following culturally responsive events. Reasons for increases in satisfaction were as follows; feeling invigorated and more comfortable, feeling valued and validated, and appreciating supervisor self-disclosure. Burkard (2006) also found that culturally unresponsive events in supervision led to decreased satisfaction. The comparison of accounts between white and BME supervisees revealed that the level of dissatisfaction felt by BME trainees was stronger in its emotional valence and led to different consequences. BME trainees were more likely to feel personally invalidated, insulted and highly angry following culturally unresponsive

events. In addition, BME trainees reported seeking support elsewhere following the event.

The Impact of Culturally Competent Supervision on Supervisee Self-efficacy

Three papers explored the impact of culturally competent supervision on trainee self-efficacy; Crockett & Hays (2015), Ng & Smith (2012), and Phillips et al., (2016). Self-efficacy is described as a practitioner's belief in their own ability to practise effectively. Self-efficacy beliefs are thought to be strongly related to effective action in clinical practise (Larson et al., 1992) and are therefore important to supervisee development.

Ng and Smith (2012) found that culture-based discussions in supervision were not related to counselling self-efficacy. This study was limited by a relatively small sample size, however, the use of hierarchical regression analysis allowed for the controlling of confounding variables; training level and English language proficiency. Crockett and Hays (2014) also found that supervisor cultural competence was not significantly related to supervisee counselling efficacy. The authors concluded that supervisor multicultural competence is not a strong predictor of supervisee self-efficacy. The sample of participants for this study notably lacked diversity with mostly white female participants, diminishing the generalisability of the findings.

Phillips et al. (2016) explored the relationship between culturally competent supervision and two types of self-efficacy; general counselling self-efficacy and multicultural counselling. Multicultural self-efficacy was defined as the perceived ability to effectively assess, integrate, and adapt to issues related to race and ethnicity in counselling (Sheu & Lent, 2007). The authors initially found a significant relationship between quality of culture-based discussion in supervision and both types of self-efficacy, however, this relationship was non-significant when stage of training was

controlled for. The study was limited by the simplistic measure of culturally responsive discussion in supervision, as it was measured by just one question.

Impact of Culturally Competent Supervision on Supervisee Clinical Practice

Five studies explored the impact of culturally competent supervision on the clinical practice of supervisees. Two quantitative studies used standardised measures of supervisee multicultural awareness, knowledge and skills (Lee & Khawaja, 2014; Vereen et al., 2008) and one used a multicultural case conceptualisation task to measure clinical practise skills (Inman, 2006). Qualitative studies elicited descriptions of changes to clinical practise through open ended interview and survey questions (Solheilian et al., 2013; Torporek et al., 2004)

Torporek et al. (2004) found that developing increased awareness and skills were the most frequently endorsed consequences of culturally competent supervision. Awareness referred to increased appreciation of cultural differences and the supervisees own culturally informed assumptions. Skill development referred to actions inspired within supervision, such as increased communication with the client around cultural issues. The authors use of surveys to provide qualitative data may have limited the depth of responses. However, the authors did gather data from supervisors and supervisees, providing multiple perspectives. Findings from the Soheilian et al. (2014) study provided similar results to Torporek et al. (2004). In addition, the derived themes suggested that addressing cultural issues in supervision directly led to the development of culturally informed formulations and interventions with the client (Soheilian et al., 2014).

Evidence of the relationship between culturally competent supervision and supervisee clinical practice has been more difficult to obtain from the quantitative studies. Inman (2006) found that supervisor multicultural competence did not have a significant relationship with supervisees' ability to complete culturally competent case

formulations. However, Inman's (2006) findings in this area are limited by methodological flaws. The measure of culturally competent case formulation was newly developed and unstandardized. Participants in the study all gained relatively low scores, suggesting a lack of sensitivity in the measure.

Vereen et al. (2008) and Lee and Khawaja (2013) conducted survey-based studies to investigate the relationship between trainee cultural competence and several aspects of practitioner training; cultural competency training courses, number of non-white clients, and culture-based discussions in supervision. Vereen et al. (2008) found that the presence of culture-based discussions in clinical supervision and the number of cultural competency courses did not significantly predict students' level of cultural competency scores. Working with a higher number of non-white clients did significantly relate to higher scores of students' cultural competency. The authors also found a significant interaction effect; seeing higher numbers of non-white clients and having culture-based discussion in supervision was significantly associated with higher levels of student multicultural competence.

Lee and Khawaja (2013) found that culture-based discussions in supervision did have a significant and direct association with trainee cultural competence. This may have been due to a slightly more sensitive measure, as Lee and Khawaja measured the number of hours spent discussing cultural issues in supervision, whereas Vereen et al. (2008) only measured the presence or absence of culture base discussions. Both research papers emphasised the importance of developing cultural competence through working with a diverse range of clients in combination with receiving culturally competent supervision. However, the conclusions drawn are limited by the lack of methodological rigour of the studies. Specifically, the failure to consistently adopt robust measures of culturally competent supervision (Vereen et al, 2008; Lee & Khawaja, 2013).

Discussion

This review aimed to consider the impact of culturally competent supervision on psychological practitioners in training. Evidence from the literature reviewed identified four main areas of impact; the supervisory relationship, satisfaction with supervision, supervisee self-efficacy and therapeutic practice. The most consistent finding was the relationship between higher levels of culturally competent supervision and increased quality of the supervisory relationship (Crockett & Hays, 2015; Gatmon et al. 2001; Howell, 2016; Inman, 2006; Ng & Smith, 2012; Phillips et al. 2016). There is also evidence that higher levels of supervisor cultural competence relate to increased satisfaction with supervision. There is a lack of sufficient evidence to confirm that supervisor cultural competence has an impact on supervisee self-efficacy or clinical practice. There is also preliminary evidence that culturally competent supervision may positively impact the practice of supervisees on a case by case basis, however, it is unclear if trainee cultural competence was improved in a broader sense.

The majority of the studies reviewed found a significant relationship between higher levels of supervisor cultural competent and increased quality of the supervisory relationship. However, a causal relationship cannot be presumed from the data reviewed. This is not necessarily problematic from a theoretical viewpoint as the presence of a positive working alliance and the demonstration of cultural competence are both identified as key requirements of proficient supervision (Dooley & Peyton-Lander, 2014). The qualitative data supports the notion that the relationship between supervisor cultural competence and a positive supervisory relationship is bi-directional. Key culturally responsive events were reported to occur within a positive supervisory relationship, and have the potential to further strengthen the relationship, allowing supervisees to continue to address cultural issues in the future (Burkard et al., 2006; McLeod, 2009).

Tools measuring supervisor multicultural competence are likely to correlate highly with measures of general supervisory competency diminishing the clarity of how cultural competence specifically contributes to the supervisory relationship. In addition to this, most supervisory competence measures were completed by supervisees, the responses to these measures may therefore have been biased by the general likeability of these supervisors, again diminishing the validity of the results. However, the studies utilising specific measures of culture-based conversation and quantifying their relationship with supervisory working alliance also demonstrated a significant relationship between the two. Whilst these measures were limited by their lack of standardisation, they may be a more specific measure of cultural responsiveness in supervision.

The qualitative studies also explored culturally unresponsive events, highlighting that the manner in which cultural issues are addressed is important. Supervisors who dismiss, ignore or criticise supervisee attempts to discuss cultural issues in supervision can damage the extent to which their supervisee trusts, respects and feels safe around them (Burkard et al., 2006; McLeod, 2009). Furthermore, these experiences may be even more harmful to BME trainees. This is in line with pre-existing qualitative literature describing the emotional impact of enduring aspects of training that fail to respect the diversity of trainees (Paulraj, 2016; Shah, 2010).

The generalisability of findings from qualitative data is limited by the small sample sizes, however, the findings of Burkard et al. (2006) and McLeod (2009) are corroborated by UK based qualitative research. A growing body of literature exploring the experience of BME trainee clinical psychologists in the UK provide compelling accounts of how painful encounters with cultural unresponsive colleagues, supervisors and organisations can be (Paulraj, 2016; Shah, 2010; McNeil, 2010; Adetimole et al., 2005). Therefore, the evidence that culturally competent supervision can have a causal

impact on changes in the supervisory relationship should not be discounted. It is worth considering the extent to which the samples included in cultural competence studies are representative. Those who volunteer to take part these studies may be more likely to have interest and experience in cultural competence. This may increase the likelihood that cultural competence is an important factor for them in supervision.

The research reviewed is suggestive of a significant relationship between supervisor cultural competence and overall satisfaction with supervision. Not surprisingly there is also evidence to suggest that this relationship is stronger when the supervisory relationship is stronger (Inman, 2006; Crocket & Hays, 2015). It should be noted that not all studies found a significant direct relationship between cultural competence and satisfaction, indicating that cultural competence alone may not be enough to influence supervisee satisfaction (Crocket & Hays, 2015). The qualitative data reviewed provides interesting insight into the impact of culturally responsive and unresponsive events in supervision, and highlights the profound impact a single demonstration of responsive or unresponsive supervision can have.

There is little evidence within the studies reviewed that supervisor cultural competence has a significant impact on supervisee self-efficacy, particularly when related variables are controlled for (Crocket & Hays, 2014). The reviewed results suggest that factors other than supervisor cultural competence are likely to influence general self-efficacy and confidence working with cultural diversity, such as stage of training (Phillips et al., 2016).

There is preliminary evidence that supervisor cultural competence can impact the clinical practice of supervisors in training. The qualitative studies clearly describe incidents in which culture-based discussions have directly influenced their self and other awareness, and the way they work clients (Sohelilian et al., 2014; Torporek et al., 2004). However, these accounts are based on single events described by a relatively

small number of participants. Quantitative data from larger samples suggests that there may be a relationship between culturally competent supervision and cultural competence in trainees, although, this may be dependent on the number of ethnically diverse clients the supervisee has worked with (Lee & Khawaja, 2013; Vereen, 2008). This conclusion is drawn tentatively as the reliability of the results is limited by methodological weaknesses (Lee & Khawaja, 2013; Vereen, 2008). In addition, the causal nature of the results cannot be determined by the cross-sectional data provided. For example, supervisees who have engaged in more discussions around cultural diversity in supervision may have instigated these discussions themselves, demonstrating pre-existing levels of cultural competence.

Strengths and Limitations of the Current Literature Review

The current review is characterised by several methodological strengths. The results of the review are based on systematically selected papers identified using a thorough search procedure. In addition to the papers identified through databases, additional studies were identified during the citation and reference searches highlighting the value of such procedures. Additionally, the selected papers were critiqued utilising a standardised quality assessment tool and the results of this process were verified with the use of a second independent researcher. The results were also critiqued narratively throughout the results section, allowing for synthesis of the quality ratings and the descriptive results.

The findings of the current review should also be considered in light of its limitations. Firstly, the inclusion criteria applied throughout the paper selection process was intentionally broad, in order to capture as many papers as possible. Whilst this allowed for the inclusion of a higher number of papers, the heterogeneity of the included studies may have had a detrimental impact on the overall quality of the conclusions outlined within the review results. For example, the included papers used a

variety of standardised and non-standardised methods to measure the occurrence and quality of culturally competent supervision. The heterogeneity of measures used may limit the extent to which the results of individual papers can be combined and compared in a valid manner. Another limitation of the current review is the lack of a dedicated grey literature search, focusing on unpublished studies. Omission of unpublished literature can bias the results of systematic reviews, as studies with significant findings are more likely to be submitted and accepted for publication. Although, four unpublished studies were identified within the literature search conducted (Breux, 2015; Diggles, 2013; Howell, 2016; McLeod, 2009).

Implications for Clinical Practise and Research

Discussing cultural and ethnic differences in supervision is commonly encouraged practise in guidelines for clinical psychologists, and associated professions, providing supervision (APA, 2003; Dooley & Peyton-Lander, 2014). Despite this, there remains some reluctance, within the profession, to routinely address these issues (Ellis & Cooper, 2013; Nolte & Nell, 2012). The results of the review suggest that discussing issues around ethnic diversity is likely to have a positive impact on the supervisory relationship, the supervisee's satisfaction with supervision and potentially influence their practice.

The literature refers to a fear of 'getting it wrong' or causing offence when addressing issues around cultural diversity, resulting in the avoidance of addressing cultural issues in any depth (McKenzie-Mavinga, 2009; Paulraj, 2016). An important message to take away from the current review is that there are in fact ways to get discussions around cultural diversity wrong, however, this is most commonly through dismissal or avoidance of the topic. At worst, supervisors involved in the research reviewed have caused offence to supervisees through criticising or belittling their ethnicity related reflections (Burkard et al., 2006; McLeod, 2009). These culturally

unresponsive actions can have a profound emotional impact on supervisees and damage the supervisory relationship. Supervisors and supervisor training courses should therefore not assume that professionals inherently possess the ability to be culturally competent. Methods of noticing and addressing issues around ethnic and cultural diversity should be taught and practised, in the same way other key therapeutic tools are, throughout the training process.

The findings also suggest that the cultural identity of the supervisee may influence their needs or beliefs about how important cultural discussions are (Burkard et al., 2006). Factors such as this could be discussed from the outset of supervision, during supervision contracting. This would serve to open the door to discussions around diversity and allow for the needs of the trainee to be explicitly heard and responded to. These conversations should not be limited to supervision of trainees from an ethnic minority background, or in relation to work with ethnically different clients, as this may limit the development of cultural competence for those who do not have opportunities to work with ethnically diverse populations (Lee & Khawaja, 2013; Vereen, 2008).

The findings discussed in the current review provide preliminary evidence for the importance of culturally competent supervision. Future research efforts adopting more stringent designs would allow for firmer conclusions to be drawn. Longitudinal studies gathering data from the perspective of trainees and their supervisors would allow for the determination of causal relationships between culturally competent supervision and areas of impact for the supervisee. The collection of data from clients is also markedly absent from the evidence base and would add insight into the potential impact of culturally competent supervision on clinical practice and client outcomes.

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Note: Asterisk indicates the studies included in the literature review.

Appendix A: QualySyst Assessment Tool for Quantitative Research (Kmet,
Lee, & Cook, 2004)

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Appendix B: QualySyst Assessment Tool for Qualitative Research (Kmet, Lee,
& Cook, 2004)

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Appendix C: Quality Rating Tables for Qualitative and Quantitative Studies

Table A1.
Quality Ratings for Quantitative Studies

Conclusions supported by the results	Results reported in sufficient detail	Confounding variables controlled	Estimate of variance is reported for the main outcomes	Analysis described and appropriate	Sample size appropriate	Measure(s) defined and robust to bias?	Blinding of subjects to intervention	Blinding of investigator reported	Random allocation described	Subject characteristics sufficiently described	Appropriate subject selection, information source and input variables	Design evident and appropriate	Objective sufficiently described?
Gatmon et al. (2001)	✓✓	✓✓	✗	✓	✓✓	✓	NA	NA	NA	✓✓	✓✓	✓✓	✓✓
Breaux et al. (2005)	✓	✓✓	✗	✓✓	✓	✓✓	NA	NA	NA	✓✓	✓	✓✓	✓
Inman 2006	✓✓	✓✓	✗	✓✓	✓✓	✓✓	NA	NA	NA	✓✓	✓	✓✓	✓✓
Vareen et al., (2008)	✓✓	✓✓	✗	✓✓	✓✓	✓	NA	NA	NA	✓✓	✓	✓	✓✓
Mori et al. (2009)	✓	✓✓	✗	✓✓	✓✓	✓✓	NA	NA	NA	✓	✓✓	✓	✓✓
Ng & Smith (2012)	✓	✓✓	✓✓	✓✓	✓	✓	NA	NA	NA	✓✓	✓✓	✓✓	✓✓
Diggles (2013)	✓	✓✓	✗	✓✓	✓	✓	NA	NA	NA	✓✓	✓✓	✓✓	✓✓
Lee & Khawaja (2013)	✓✓	✓✓	✓	✓✓	✓✓	✓	NA	NA	NA	✓	✓✓	✓✓	✓✓
Crockett & Hays (2015)	✓✓	✓✓	✓	✓✓	✓	✓✓	NA	NA	NA	✓✓	✓✓	✓✓	✓✓
Howell (2016)	✓	✓✓	✗	✓✓	✓	✓✓	NA	NA	NA	✓✓	✓	✓✓	✓
Phillips et al. (2016)	✓✓	✓	✓	✓✓	✓	✓	NA	NA	NA	✓✓	✓✓	✓✓	✓✓

Table A2.
Quality Ratings for Qualitative Studies

Reflexivity of the account?	Conclusions supported by the results?	Use of verification procedure(s) to establish credibility?	Data analysis clearly described and systematic?	Data collection methods clearly described and systematic?	Sampling strategy described, relevant and justified?	Connection to a theoretical framework / wider body of knowledge?	Context for the study clear?	Study design evident and appropriate?	Question / objective sufficiently described?
✓	✓	✓✓	✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓	✓✓	✓✓
✓✓	✓✓	✓✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
✓	✓	✓✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓

Section Two: Research Project

Comparing the Profile of Psychological Service Use Between Black and
Minority Ethnic Groups and Non-Ethnic Minorities: Intake, Outcomes and Processes

Abstract

Objectives: To investigate the possibility of ethnic inequalities occurring across psychological services in the United Kingdom. The study focused on differences occurring at therapy intake and across therapy outcomes and processes for Black, Asian and ‘Other’ ethnic minority groups.

Design: Data collected as part of routine clinical practice was drawn from an archived CORE Research National Dataset. The data was used to determine variation across the variables of interest, according to ethnicity.

Methods: All patients for whom ethnicity and presenting problem severity was known were included in at least one stage of the analysis (N=78,962). Variation across ethnic groups at intake was measured using pre-therapy scores of psychological distress and the outcome of assessment (accepted for therapy or not). Variation across therapy outcomes was measured using drop-out rates, psychological improvement and psychological deterioration. Differences in therapy processes were measured by frequency and number of therapy sessions and perceived engagement.

Results: Patients from ethnic minority backgrounds (Black, South Asian and Other) presented to services with significantly higher levels of psychological distress and subsequently had poorer psychological outcomes following therapy. Belonging to South Asian and Other ethnic minority groups increased the odds of a patient deteriorating following a course of therapy. Patients from Black and South Asian ethnic minority groups had increased odds of dropping out of therapy. Patients from Black, Other and Asian ethnic minority groups were also more likely to be perceived as having a poorer quality of engagement in therapy.

Conclusions: This study provides evidence that people from ethnic minority backgrounds present differently, achieve different outcomes and are perceived differently by therapists in comparisons to their white counterparts.

Practitioner Points

- Equal access and outcomes for people from Black, Asian and ethnic minority backgrounds need to be monitored locally by psychological services.
- Perceived engagement in therapy may be influenced by a patient's ethnicity. Reasons for this should be explored using reflective practice and open dialogue with clients.

Limitations

- Parts of the analysis were based on relatively small sample sizes for some ethnic minority groups.
- The ethnic groups used for comparison (White, South Asian, Chinese, Black and Other) are likely to be made up of individuals from heterogeneous ethnic and cultural backgrounds.
- The use of routinely collected data resulted in high levels of missing data for some variables of interest.

Ethnic inequalities in mental healthcare in the United Kingdom (UK) have been a consistent cause for concern for the past three decades (Department of Health [DH], 1999; DH, 2003; DH, 2005; Mental Health Foundation, 2015; Sizmur & McCulloch, 2016). There is also a recognition that despite detailed documentation and extensive discussion of these inequalities, little has changed (DH 2010; Grey, Sewell, Sahpiro & Ashraf, 2013). Examples of this phenomenon can be still be seen in recent research findings. Black and South Asian service users are significantly more likely to be detained under the mental health act (Weich et al., 2013) and significantly less likely to be referred, by primary healthcare providers, to psychological therapy services (Brown, Ferner, Wingrove, Aschan, Hatch & Hotopf, 2014). Patients from Black and minority Ethnic (BME) groups have also repeatedly been found to express more dissatisfaction with their mental health treatment in comparison to White patients (Mind, 2011; Sandamas & Hogman, 2000).

Lack of equitable community services may influence the persistent inequalities apparent in mental health care for people from BME backgrounds. Patients from Black, Asian and other ethnic minority backgrounds are underrepresented within primary care and psychological therapy services (Fatimilehin & Dye, 2003; Keating, Robertson, McCulloch & Francis, 2002; Sashidharan, 2003) yet over-represented in inpatient settings (Weich et al., 2014). They are also more likely to be treated for mental health problems at a point of crisis (Bhui, et al., 2003). Mental health treatment provided for people from BME groups is more likely to be characterised by coercion and restrictive care (Keating & McCulloch, 2002). This emphasises the importance of increasing our understanding around the extent to which services in the community are equitable across ethnic minority groups in the UK.

Over the past 10 years mental health services in the community have evolved with a push toward increasing access to effective and evidence based psychological

therapies (Layard, Clark, Knapp, & Mayraz, 2007). The DH has heavily invested in developing a workforce of psychological therapists to deliver evidence based psychological therapies for mild to severe mental health problems. Ensuring that access to, and outcomes within, these services is not hindered by people's ethnicity has also been highlighted as an important priority (Williams, Turpin, & Hardy, 2006), particularly given the widespread inequalities previously highlighted within the mental health care system (DH, 2003).

Explaining Ethnic Inequalities in Mental Health Care

There is a lack of certainty regarding the causal factors of ethnic disparities across mental health services. Three areas often discussed within the literature are (1) experiences of racism and discrimination, (2) patterns of help-seeking, and (3) socioeconomic factors

Racism and discrimination. There has been a growing recognition that the operational procedures, attitudes and behaviours can result in processes which disproportionately disadvantage those from minority ethnic groups, effectively resulting in institutional racism (Keating & McCulloch, 2002). The concept of institutional racism has historically been contested, largely due to the perception that it also implicates individual racism causing concern amongst front-line workers (Foster et al., 2005). Additionally, it has been argued that the concept lacks theoretical clarity (Miles & Brown, 2003) and utility (Innes, 1999). However, the recognition of institutional racism continues to hold importance for practitioners and researchers exploring the persistence of ethnic inequalities in mental healthcare (Keating & McCulloch., 2002; Mental Health Providers Forum and Race Equality Foundation, 2015; Sewell et al., 2013).

Phillips (2011) provides a conceptual multilevel framework of institutional racism applicable to mental healthcare services. Phillips (2011) refers to processes

occurring at meso, micro and macro levels which may produce and maintain ethnic inequalities. Meso level processes describe societal and political factors that may influence individual perceptions of people from ethnic minority backgrounds. Examples of this are the political discourse surrounding the negative impact of migrants on 'British' society and the depiction of black men in the media as uneducated criminals (Welch, 2007). Meso level factors may filter down to inform micro level processes which maintain inequality; for example, the disproportionate rate of compulsory detention of black males may be due to culturally informed expressions of distress being interpreted by professionals as dangerous (McKeown & Stowell-Smith).

Macro-level processes refer to organisational procedures that, regardless of intent, disadvantage people from ethnic minority backgrounds disproportionately. An example of this within mental healthcare may be the dominance of Eurocentric conceptualisations of psychological distress, which may alienate individuals whose minority culture provides an alternative explanation (Keating & McCulloch, 2002).

Patterns of help seeking. The Eurocentric model of mental health adopted by services in the UK may also influence the help-seeking behaviour of some people from BME backgrounds (Fernando, 1991). In interviews with Black African service users, Anthony (2015) found that several participants did not define experiences of distress as mental health problems and therefore did not see themselves as requiring professional help. Subsequently, participants described only seeking help when they felt they had reached a point of crisis. Reluctance to seek help amongst Black African communities was also attributed to feelings of shame and fear of being stigmatised by peers and pathologized by services (Anthony, 2015; Yorke, Voisin, Berringer, & Alexander, 2015). These issues have been described elsewhere for Black Caribbean help seekers (Edge, 2013; Edge & Rogers, 2005; Myrie & Gannon, 2013) and within Pakistani and Bangladeshi populations (Bhardwaj, 2001; Kumari, 2004). Alternative beliefs about

mental health and predicting that seeking help will lead to negative consequences can result in delayed, or a lack of, voluntary help seeking within some BME communities (Edge & MacKian, 2010; Scheppers, 2006).

Socioeconomic factors. It has been argued that ethnic inequalities in mental health care can be attributed to higher levels of social and economic disadvantage rather than ethnicity itself (Singh, Tyrer, Islam, Parsons, & Crawford, 2014). It is known that there is a strong relationship between social disadvantage and mental health problems (Marmot et al., 2010) and that Black, Asian and Ethnic minority families are disproportionately disadvantaged when it comes to employment, income, education and housing (Garret et al., 2014). This has been partially supported by research exploring ethnic variations in compulsory admissions. Gajwani, Parsons, Birchwood, and Singh (2016) found that when confounding factors such as age, gender, social support and markers of socioeconomic status were controlled for, the significance of ethnic minority status was eliminated. However, Sashidharan, Bhui and Duffy (2013) argue that denying the independent role of ethnicity on experiences in mental health care, denies the experience of BME individuals who have faced discrimination, exclusion or negative interaction within services or society, because of their ethnic background, and allows for maintenance of the status quo.

Once engaged with mental health services there is mixed evidence regarding the experience of patients from ethnic minority backgrounds. People from ethnic minority backgrounds are more likely to disengage with services (O'Brien, Fahmy, & Singh, 2009; Rathod, Kingdon, Smith & Turkington, 2005) or have 'broken contact' (McGovern & Cope, 1991). Patients from BME backgrounds are also more likely to be admitted to inpatient units as opposed to respite centres during a mental health crisis (Lawlor, Johnson, Cole, Louise, & Howard, 2010), and are less likely to be referred for talking therapies (Keating, Robertson, & Kotecha, 2003). However, these findings have

not been corroborated by recent qualitative studies, which suggest that patients from BME groups are satisfied with the care they have received from community mental health services (Islam, Rabiee, & Singh, 2015). Moreover, they do not perceive that their ethnic minority status impacted upon their experience of care (Weich et al., 2012).

Along with a lack of clarity, there is also a lack of detail within the current evidence base exploring ethnic inequalities in mental health care. Studies often focus on a single outcome, such as rate of inpatient admission, referral to therapy or satisfaction with services. There is limited information regarding the journey of patients from ethnic minority backgrounds through services and whether this is influenced by their ethnicity. Surprisingly, there is also a lack of evidence from UK services based in the community, such as psychological therapy services.

Access and Outcomes for BME groups accessing community psychological services

Under the Race Relations Amendment Act (2000) it is a legal requirement for all public organisations to promote race equality. This requires psychological services to ensure equal access and outcomes across ethnic groups. A positive practice guideline was developed in 2009 to guide the development and delivery of equitable and effective psychological services for BME people (DH, 2009). The guidelines recommend that psychological services should ensure accessibility to people from Black, Asian and minority ethnic backgrounds through gaining knowledge of the ethnic composition of the local area and developing links with third sector services. Voluntary and third sector services are often designed to cater to the needs of people from minority or disadvantaged backgrounds and are often thought to have a better knowledge of ethnic minority communities (Mental Health Providers Forum & Race Equality Foundation, 2015). However, the extent to which psychological services

actively commit to monitoring and delivering equitable services for BME service users is inconsistent (McKenzie & Bhui, 2007).

Culturally competent psychological therapists are also an important part of culturally sensitive service delivery (DH, 2009). Cultural competence guidelines for psychologists recommend that therapists be aware of how cultural issues may impact a person's presentation and understanding of their distress. The acceptability of psychological interventions should also be considered in light of a person's cultural, spiritual or religious beliefs (Division of Clinical Psychology, 2015). Psychological practitioners are also encouraged to be aware of their own explicit and implicit prejudices, which may impact their view and subsequent treatment of ethnic minority patients (Brown, 2009).

To monitor the equitability of services it is recommended that outcome data should be routinely collected and evaluated to determine the equality of service access and outcomes (DH, 2009). In 2011, the Royal College of Psychiatrists (RCP) compiled a national audit reporting on the delivery and quality of psychological services being delivered around the UK (RCP, 2011). The audit data suggested that the proportion of BME individuals accessing psychological services was consistent with the reported proportion of ethnic minorities in the wider population (14%; Office of National Statistics, 2011). It was concluded that people from BME backgrounds were not disadvantaged regarding access to psychological services (RCP, 2011). This finding was also echoed in the second round of National Audit of Psychological Therapies completed in 2013 (RCP, 2013).

Similarly, recent data published as part of the Increasing Access to Psychological Therapies (IAPT) programme reports that in 2016, 14.9% of service users who completed a course of therapy were from a BME background (Health and Social Care Information Centre [HSCIC], 2017). However, the recovery rate for BME

groups was 45% whilst the recovery rate for the White British group was 49.4%. A lower rate of recovery amongst BME service users was also observed for the data collected in 2015 and 2014 (HSCIC, 2016).

Unfortunately, the value of the data available through the RCP and HSCIC is limited in what it can tell us about significant differences across ethnic groups. Firstly, there are no statistical analyses completed to assess whether access or outcome rates differ significantly for ethnic minority groups. Secondly, both sets of data fail to consider the heterogeneity of BME groups as the data for all non-white patients have been grouped together into one BME group.

Clark and colleagues (2009) conducted statistical comparisons of outcomes for individuals from White, Black, Asian and Other ethnic backgrounds being treated for anxiety and depression using Cognitive Behavioural Therapy (CBT). This study found that psychological improvement following therapy was similarly achieved across all ethnic groups. This suggests that once people are accessing and using psychological therapy services, improvements in mental health distress may be achieved equally across ethnicities. However, most patients within the Clark et al. (2009) study received guided self-help for mild-moderate anxiety or depression. This finding may not be generalizable to service users accessing psychological services for more complex needs.

There is also research suggesting that psychological services are not equitable for ethnic minority patients. MIND (2013) conducted a survey of 1600 people using psychological services. Focus groups with 10 BME people were also conducted to specifically explore their needs and experiences when accessing psychological services. One third of survey respondents stated that psychological services did not meet the needs of BME communities, and 9 out of 10 people indicated their own cultural needs had not been addressed. Themes from the focus group indicated that the main barriers

for BME participants in accessing and utilising services were expectations that their culture would not be understood, and language barriers for people who did not have English as their first language (MIND, 2012).

A qualitative study exploring the experience of Black African people who had engaged with psychological therapies (Anthony, 2015) found that ethnicity and culture influenced the way services were used and perceived. Participants made reference to feeling pathologised by services as labels were attributed to their experiences. Several participants described shame, reluctance and uncertainty about discussing their problems with professionals. For several of the participants, help was only sought when a point of personal crisis was reached (Anthony, 2015). Similarly, a small-scale service evaluation exploring the experience of nine Asian and “Mixed Race” service users engaging in psychological therapy suggested that belonging to an ethnic minority group was associated with negative perceptions of therapy. Service users indicated that they felt their faith and culture was not adequately considered and around half of the participants felt misunderstood and unheard (Agoro, 2014).

Whilst cultural competence is a core requirement for therapists and counsellors, the theoretical underpinnings of the psychological models commonly used may be less effective for some BME service users (Dryden & Branch, 2012). The National Institute for Health and Care Excellence (NICE) provide clear guidance on the delivery of evidence based psychological therapies. However, the clinical trials informing these guidelines consistently fail to recruit an adequate number of participants from BME backgrounds (Brown, Marshall, Bower, Woodham, & Waheed, 2014). Bhui et al. (2015) argues that some psychological approaches may conflict with cultural, spiritual or religious beliefs more likely to be adopted by individuals from ethnic minority backgrounds.

Psychological approaches often favour individualistic perceptions of wellbeing, such as achieving self-actualisation. In contrast, some other world cultures originating in Asia and Africa place more importance on the collective function of the family unit (Bernal & Sáez-Santiago, 2006). Some psychological models also take a problem-solving approach, encouraging rational identification of unhelpful and helpful thoughts. Patients may then be expected to take control over changing thought processes and behaviours to promote wellbeing. This has been found to clash with the values and beliefs held by South Asian and Chinese people who expressed the desire to abide by their own value-based and religious rules, regardless of resulting distress (Hays, 2014; Tam & Wong, 2007). Furthermore, adhering to non-Eurocentric explanatory models of psychological problems can lead to patients being deemed as lacking insight or psychological mindedness. This is detrimental to people from BME backgrounds wanting to engage in therapy and a missed opportunity for clinicians to understand and work using different cultural perspectives (Alreja, Sengar, Singh, & Mishra 2009).

Trials of culturally adapted psychological therapy suggest that it is effective in reducing psychological distress for individuals from Black and South Asian clients (Rathod, Kingdon, Phiri, & Gobi, 2010). However, it is unclear to what extent therapists routinely use culturally informed approaches in standard practice. Additionally, there is only preliminary evidence to suggest that culturally adapted approaches are superior to standard approaches (Afuwape et al., 2010; Chowdhary et al., 2014). There are several research trials indicating that various forms of psychological therapy, CBT, family therapy and narrative therapy, are effective for Chinese (Ran et al., 2003), African and Caribbean (Byrne et al., 2011) and South Asian (Rathod et al., 2010) groups. However, these trials are often conducted within specialist settings with clinicians who are experienced in working with the target client group.

There is very little evidence derived from UK based ethnic minority populations seen within routine clinical practice.

The Research Gap

Despite the persistent ethnic inequalities observable within the mental health care system, research often focuses on inpatient settings or the accessibility of community based services. Research into culturally informed help seeking behaviours and beliefs about psychological wellbeing highlight factors that may be relevant to the way in which people from BME backgrounds interact with psychological services. However, there is a lack of empirical research in this area.

To address this gap in the literature the current research aimed to establish the profile of service users presenting to psychological services in the UK and to investigate the possible ethnic inequalities which may occur between BME patients and White patients. Data from NHS psychological services and non-NHS services were used. Due to the paucity of research from non-NHS services, differences across sectors were also briefly examined for descriptive comparisons.

Research Aims

To investigate the possibility of ethnic inequalities occurring at intake, in therapy outcomes, and across therapy processes. The specific research questions addressed are as follows:

- 1) Are there significant differences at therapy intake between ethnic groups presenting to services?
 - a. Presenting problem severity
 - b. Rate of acceptance for therapy
- 2) Do therapy outcomes significantly differ across ethnic groups, based on the following criteria:
 - a. Drop-out rates

- b. Psychological change
 - 3) Are there significant differences in therapy processes between ethnic groups?
- Processes are defined as:
- a. Length and frequency of therapy delivery
 - b. Perceptions of patient engagement
- 4) Are BME service users more likely to access NHS or non-NHS services?

Method

Full Dataset

The study used practice-based evidence collected routinely within psychological therapy services across England. The data was drawn from the CORE National Research Database 2011, which comprised data collected over a 12-year period. Ethical approval for the study was covered by the Leeds Research Ethics Committee, application 05/Q1206/128 (Appendix A). The original database included data from 104,474 patients seen between 1999 and 2011.

Study-specific Dataset

The study-specific data set was defined by including patients who had recorded data for key variables. Patients who did not have data concerning their ethnicity, age, gender or employment status were therefore excluded ($N = 25,512$). The group of patients excluded were significantly younger, $t(94,107) = -39.70$; and more likely to be unemployed, $\chi^2(1, N = 82,892) = 204.27, p < .001$. There was a significant difference in the ethnic make-up across the two groups $\chi^2(4, N = 92,204) = 1008.95, p < .001$. The excluded sample included 77.3% of people identifying as White, compared to 87.1% in the included sample. There were no significant differences in presenting problem severity, $t(79,328) = 2.05, p = 0.04$, and gender, $\chi^2(1, N = 96,515) = 6.32, p = .012$. Due to the large size of the data set the threshold for significance was $p < .01$.

The full demographic details for patients included in the study-specific data set are available in Table 1. The study-specific data-set comprised 78,962 patients (52,963 female) with a mean age of 35.78 ($SD = 13.26$) years. Patients were seen across NHS services (primary, secondary and tertiary) and non-NHS services (voluntary, workplace, university and private). Regarding ethnicity, 68,741 (87.1%) of patients were White (White British, White Irish, or White European), 3,640 (4.6%) were South Asian (Indian, Pakistani, Bangladeshi or Other Asian), 559 (0.7%) were Chinese, 3,306 (4.2%) were Black (African, Caribbean or Black Other), and 2,716 (3.4%) indicated belonging to the Other ethnic minority group.

The majority of patients lived with family, friends or partners and were employed or identified as occupying an 'Other role' such as student or house-person. Diagnosis was not formally assessed. However, therapists rated the subjective severity of several presenting problems based on information gathered at assessment. Presenting problems causing some level of difficulty (mild to severe) within the current population were as follows: anxiety (66.8%), depression (54%), interpersonal (50.7%), self-esteem (41.5%), bereavement (27.3%), and trauma (19.9%). The most frequently adopted therapy modalities were integrative (20138, 25.5%) person-centred (10718, 13.6%), psychodynamic (6891, 8.7%) and cognitive behavioural (4586, 5.8%). Therapy modalities endorsed in less than 5% of cases were brief structured therapy, psychoanalytic therapy, systemic therapy, supportive therapy, art therapy, cognitive therapy, and behavioural therapy. Therapy approach was not specified for 37.9% of patients ($N = 29,942$).

To address each research question, further exclusion criteria were applied to the dataset incrementally at each stage of the analysis (see Procedure section).

Table 1
Patient Demographics for The Study-Specific Data-set

		N	%
Gender			
	Female	52,963	67.1
	Male	25,999	32.9
Employment			
	Employed	40,395	51.2
	Other Role	24,511	31.0
	Unemployed	14056	17.8
Ethnicity			
	White	68,741	87.1
	South Asian	36,40	4.6
	Chinese	559	0.7
	Black	3,306	4.2
	Other	2,716	3.4
Mild-Severe Presenting Problems			
	Anxiety	52,733	66.8
	Depression	42,602	54.0
	Interpersonal difficulties	40,009	50.7
	Self-esteem	32,731	41.5
	Bereavement	21,565	27.3
	Trauma	15,722	19.9
Living Arrangements			
	Living Alone	14,054	17.8
	Living with partner	15,452	19.6
	Living with children	21,472	27.2
	Living with friends/family	10,641	13.5
	Shared Accommodation	9,589	12.1
	Other	1,761	2.4
	Unknown	5,991	7.6
Service Type			
	NHS		
	Primary care	20,953	26.5
	Secondary care	4,995	6.3
	Tertiary care	2,509	3.2
	Non-NHS		
	Voluntary	17,812	22.6
	University counselling	17,793	22.5
	Workplace counselling	14,472	18.3
	Private	428	0.5

Measures

Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM).

The CORE-OM (Barkham et al., 2001) is used in conjunction with the CORE database. It is a 34-item self-report inventory of subjective well-being, distress (anxiety, depression, physical problems, trauma), functioning (general, social and within close relationships) and risk (risk of harm to self and risk to others). Items are scored on a five-point scale indicating severity of symptom (*'not at all'*, *'only occasionally'*, *'sometimes'*, *'often'* and *'all or most of the time'*). Clinical scores for the CORE-OM are calculated as the mean score of completed items multiplied by 10, this is to aid the identification of clinical differences represented by whole numbers (Stiles, Barkham & Wheeler, 2015). A copy of the CORE-OM measure is included in Appendix B. The CORE-OM pre-therapy and post-therapy scores were used to assess psychological outcomes across the course of therapy. The CORE-OM has been tested for suitability and utility in observing clinically significant change in the severity of mental health problems (Connell et al., 2007). The 34-item scale has a reported internal consistency of .94 (Barkham et al., 2001) and a 1-month test–retest correlation of .88 (Barkham et al., 2001). The recommended clinical cut off score for the CORE-OM is 10, with scores above this indicating a level of psychological distress significantly higher than would be expected within a non-clinical population (Connell et al., 2007).

CORE Therapy Assessment Form and CORE End of Therapy Form.

Further patient data was gathered from information recorded by the therapists before and after therapy. Upon assessment, therapists complete the CORE Therapy Assessment Form (Barkham, Mellor-Clark, Connell & Cahill, 2006; Appendix C) and at the end of treatment, therapists complete the CORE End of Therapy Form (Barkham et al., 2006; Appendix D). These forms provide various details for each patient; demographic characteristics, living circumstances, presenting problem severity and

duration, details of medication and details of substance use. The therapy assessment form also indicates whether patients are accepted for therapy or deemed unsuitable. Following therapy, practitioners provide information about the completed treatment and its outcomes. This includes a review of the presenting problem, the number of sessions the patient attended, whether the ending was planned or unplanned, therapy modality used and ratings of patient motivation, psychological mindedness and therapeutic alliance.

Procedure

The research questions guided the selection of appropriate variables from the dataset. Ethnicity was a key variable of interest, as were measures relating the presentation of patients at intake, therapy processes, therapy outcomes and service type. Age, gender and employment status were identified as potentially confounding variables to be controlled for during the analysis. Welfare and substance use problems were also considered for inclusion as markers of economic stability and problem complexity. However, these variables had high rates of missing data (Welfare Problems = 84.1%; substance addiction = 95.7%) and were subsequently excluded.

To answer the four research questions outlined some variables required calculating, coding and/or collapsing for the purposes of the analysis. Filters variables were also created to select the relevant patients to answer the question being asked of the data at different stages of the analysis. This process is described below.

Ethnic variations at intake. All participants whose ethnicity, age, gender, employment status, pre-therapy CORE-OM scores were recorded were included ($N = 78962$). The pre-therapy CORE-OM scores were used to identify differences in presenting problem severity at intake. From this sample, acceptance for therapy was defined by coding patients based on whether they were accepted for therapy or not (0 = Accepted, 1 = Not accepted). ‘Accepted’ patients had been accepted for a course of

therapy or a trial period of therapy. ‘Not accepted’ patients were offered assessment only, consultation only, were referred elsewhere or were deemed unsuitable for therapy. If the outcome of assessment had not been recorded and a patient subsequently attended 3 or more sessions they were coded as ‘accepted’. A total of 78,076 patients had defined assessment outcomes.

Ethnic variations across therapy outcomes. Drop-out rates and psychological change variables were defined and calculated. From the sample described above ($N = 78,962$) therapy drop-out was coded. Therapist descriptions of “planned” or “unplanned” therapy endings were used to create a numerical variable with two levels (0 = planned ending, 1 = dropped out). A total of 55,440 patients had data describing the nature of the therapy ending.

Psychological change was assessed in three ways for patients who had valid pre-therapy and post-therapy CORE-OM measures and had attended at least two sessions ($N = 32,159$).

1. Post-therapy change. Change in psychological distress following therapy was calculated using the difference between pre-therapy and post-therapy CORE-OM scores.

2. Reliable and clinically significant improvement. A variable was calculated to determine whether the post-therapy change reached the criteria of reliable and clinically significant improvement (RCSI). RCSI was determined using the method outlined by Jacobson and Truax (1991) and is based on identifying a reliable change index (RCI) point, at which change observed significantly exceeds the measurement error of the instrument. The RCI for the CORE-OM has been identified as 4.5 (Stiles et al., 2015). Patients whose CORE-OM scores decreased by 4.5 points or more, and whose post therapy score was below the clinical cut of point (10) were considered to have achieved RCSI. For RCSI calculations patients were only included if they had a

pre-therapy CORE-OM score within the clinical range (10 or above), as clinically significant improvement is defined by starting within the clinical range and ending out of the clinical range (Connel et al., 2007). The total number of patients included in RCSI calculations was 28,570.

3. *Reliable Deterioration.* A variable was also created to categorise patients whose psychological distress had worsened following therapy. Using the RCI described above, patients whose CORE-OM scores increased by 4.5 points, or more, following therapy were categorised as having reliably deteriorated.

Ethnic variations across therapy processes. Therapy processes were defined as the number and frequency of therapy sessions attended, and perceived engagement.

Number and frequency of sessions. Number of sessions was determined by information recorded by therapists. Therapists also recorded the frequency of patient sessions; more than once per week, weekly, less the once per week or not at a fixed frequency. These categories were collapsed into one coded variable with two levels (0 = weekly or more, 1 = less than weekly). A total of 32,159 patients had completed data for number of sessions and 29,969 patients had frequency of sessions data.

Perceived engagement. Perceived engagement was defined across three therapist-rated variables; patient motivation, therapeutic working alliance and psychological mindedness. For each variable, ratings of ‘poor’, ‘moderate’ or ‘good’ were given. For all three engagement items, therapist ratings were collapsed into 2 categories indicating whether patients had been rated as ‘good’ (coded 0) or ‘poor-moderate’ (coded 1). A total of 27,534 patients had motivation ratings, 27,513 had working alliance ratings, and 27,481 had psychological mindedness ratings.

Figure 1 shows the number of participants included and excluded at different stages of the analysis.

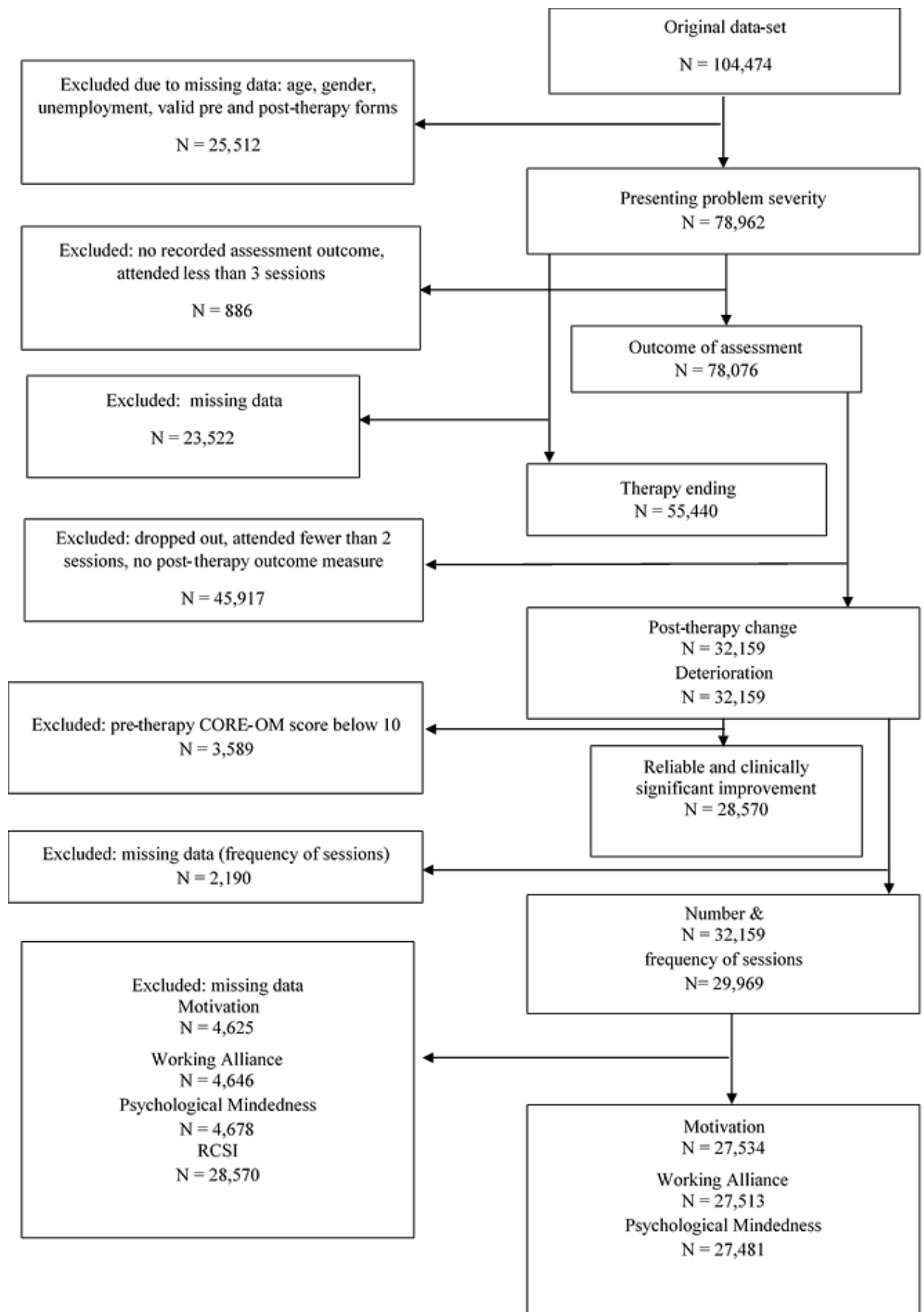


Figure 1. A flow-chart describing the inclusion and exclusion of patients at different stages of the analysis.

Data Analysis

Chi square tests were used for significance tests with categorical data and Analysis of Variance (ANOVA) tests were used with continuous data. Across all analyses ethnic group membership (White, South Asian, Chinese, Black and Other) were entered as the independent or predictor variable. Significant Chi square and ANOVA test results were followed by hierarchical logistic regression (categorical outcome data) or hierarchical linear regression (continuous outcome data).

Hierarchical regression was used to evaluate, and distinguish between, the contributions of each variables entered into the model. Ethnic group membership was, entered into the model last in order to identify its contribution to variation in the outcome of interest whilst controlling for age, gender, unemployment and pre-therapy symptom severity. For all regression analyses, age and gender were entered into step one, unemployment and presenting problem severity were entered into step two and ethnic groups were entered into step three.

Preliminary Analysis

Visual inspection of the graphical outcome data for continuous variables (pre-therapy CORE-OM scores and post therapy change) were deemed to approximate normal distribution. However, visual exploration of the number of sessions attended did not appear to be normally distributed. The ANOVA is considered to be a robust test in the face of non-normal data, particularly where the data set is large (Lix, Keselman & Keselman, 1990). In light of this, the method of analysis was not changed in response to inspection of the data. The assumption of homogeneity of variance was not met for the continuous outcome data and therefore Welch's adjusted F ratio is reported where ANOVAs have been conducted.

For data analysed using linear regression, assumptions of linearity, independent observations, and approximate normal distribution of the regression line residual errors,

were consistently met. Levels of multicollinearity were also consistently satisfactory. For the data analysed using logistic regression assumptions of linearity and independence of observation were met. Multicollinearity between variables was satisfactory. Case wise diagnostics revealed multiple cases with residual values exceeding 2.5. The presence of outliers seemed to be a consistent feature of the data across several variables, particularly when the dataset being analysed was at its largest. Due to the large sample size and the variation which may naturally within clinical settings, outliers were not removed. Due to the large amount of data available for analysis, the threshold for significance was set at $p < .01$.

Results

At intake, patients had a mean pre-therapy CORE-OM score of 18.11 ($SD = 6.61$) and 70,558 (89.4%) were accepted for therapy. A total of 16,915 (23.5%) patients dropped out of therapy after an average of 4.49 ($SD = 7.50$) sessions. Patients who completed therapy ($N = 32,195$), completed an average of 9.57 ($SD = 11.98$) sessions and had a mean post-therapy CORE-OM score of 8.85 ($SD = 6.41$), yielding a pre-post therapy effect size of 1.41. The number of therapy completers starting within the clinical range ($N = 28,570$) and achieving RCSI was 19,175 (67.1%). The number of patients who reliably deteriorated was 594 (1.8%). Table 2 shows mean presenting problem severity, drop-out rate, rates of RCSI and reliable deterioration across ethnic groups, and service type (NHS and non-NHS).

Question 1. Are there Differences at Therapy Intake Between Ethnic Groups Presenting to Services?

Presenting problem severity. Presenting problem severity significantly differed according to ethnic group membership, $F(4, 3028.02) = 98.151, p < .001$. Ethnic

Table 2
Presentation and Outcomes for NHS and Non-NHS Patients, According to Ethnicity

Ethnic Group	Presenting Problem Severity		Dropout		RCSI Count		Reliable Deterioration	
	Mean (<i>SD</i>)		<i>n</i> (%)		<i>n</i> (%)		<i>n</i> (%)	
	NHS	Non-NHS	NHS	Non-NHS	NHS	Non-NHS	NHS	Non-NHS
White	18.9 (6.8)	17.3 (6.4)	5,540 (30.5)	9,014 (31.1)	5,903 (57.7)	9,396 (58.3)	164 (1.6)	259 (1.6)
South Asian	20.7 (7.4)	19.4 (6.5)	124 (28.0)	718 (40.7)	101 (41.6)	327 (40.8)	5 (2.1)	24 (3.0)
Chinese	21.3 (6.4)	17.8 (6.3)	5 (17.9)	78 (29.3)	8 (57.1)	78 (57.8)	0 (0.0)	1 (0.7)
Black	20.7 (7.5)	18.6 (6.8)	73 (34.4)	753 (38.8)	44 (44.0)	437 (46.0)	2 (2.0)	18 (1.9)
Other	20.7 (7.2)	18.9 (6.7)	96 (31.8)	439 (35.7)	57 (42.2)	278 (47.2)	7 (5.2)	21 (3.6)

group membership, CORE-OM means, standard deviations and standard errors (*SEs*) of presenting problem severity are displayed in Table 3.

Ethnic minority group membership accounted for significant additional variance in pre-therapy CORE-OM scores when controlling for age, gender and employment status. Adding ethnic groups to the regression model explained an additional 0.4% of the variation in pre-therapy CORE-OM scores. This change in R^2 was significant $\Delta F(4,78954) = 87.819, p < .001$. Age, gender and unemployment explained 3.9% of variance, $\Delta F(1,78958) = 3185.72, p < .001$. The full regression statistics are reported in Table 4.

Table 3
*Ethnic Group Sample Size and Mean Pre-therapy CORE-OM Scores
Across Ethnic Groups*

Ethnicity	<i>N</i>	Mean (<i>SD</i>)	<i>SE</i>
White	68,741	17.93 (6.56)	.03
South Asian	3,640	19.72 (6.75)	.11
Chinese	559	18.16 (6.36)	.27
Black	3,306	18.93 (6.95)	.12
Other	2,716	19.36 (6.89)	.13

Belonging to South Asian, Black and ‘Other’ ethnic minority groups was significantly associated with having higher pre-therapy CORE-OM scores. Within the data set the ‘average’ patient (White, female, employed and 36 years old) would have a predicted pre-therapy CORE-OM score of 18. This compares with the following predicted pre-therapy CORE-OM scores for patients with equivalent demographic characteristics who were South Asian (19.69), Black (18.81), or of Other ethnicity (19.23). Being of Chinese ethnicity was not significantly associated with higher pre-therapy CORE-OM scores.

Table 4
Results of the Hierarchical Multiple Regression Analyses Predicting Presenting Problem Severity from Ethnic Group Membership

		Coefficients						Model Summary			
		<i>B</i>	<i>SE</i>	<i>Beta</i>	<i>t</i>	95% CI		<i>p</i> value	$\Delta F(d.f.)$	R^2	ΔR^2
						Lower	Upper				
Step 1	Age	-.016	.002	-.032	-9.087	-.020	-.013	<.001	88.385 (2,78959)	.002	.002
	Gender	-.483	.050	-.034	-9.648	-.581	-.385	<.001			
Step 2	Age	-.041	.002	-.080	-22.223	-.044	-.037	<.001	3185.721 (1,78958)	.041	.039
	Gender	-.594	.049	-.042	-12.099	-.689	-.497	<.001			
	Unemployment	3.501	.062	.202	56.442	3.377	3.620	<.001			
Step 3	Age	-.037	.002	-.072	-20.023	-19.858	-.033	<.001	87.819 (4,78954)	.045	.004
	Gender	-.611	.049	-.043	-12.469	-12.462	-.514	<.001			
	Unemployment	3.474	.062	.201	56.091	56.097	3.593	<.001			
	S. Asian	1.693	.110	.054	15.341	15.375	1.912	<.001			
	Chinese	.412	.275	.005	1.499	1.526	.958	.134			
	Black	.813	.115	.025	7.059	7.094	1.041	<.001			
	Other	1.228	.127	.034	9.691	9.692	1.475	<.001			

Rate of acceptance for therapy. A significant relationship was found between ethnic group membership and being accepted for therapy $\chi^2 (4, N = 78076) = 35.09, p < .001$. The acceptance rates for therapy, across ethnic groups, are displayed in Table 5.

Ethnic minority group membership was significantly associated with not being accepted for therapy when controlling for age, gender, unemployment and presenting problem severity, $\chi^2 (8) = 392.35, p < .001$. The variables controlled for were also significantly associated with dropping out of therapy $\chi^2 (4) = 368.46, p < .001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.1% of variance in the outcome. Age, gender, unemployment and presenting problem severity explained 1% of the variance in outcome.

Belonging to the ethnic group Other significantly increased the odds of not being accepted for therapy, OR = 1.3 (95% CI, 1.15-1.46), $p < .001$. The odds of not being accepted for therapy were not significantly increased for South Asian, Chinese or Black ethnic minority group. The full regression statistics are shown in Table 6.

Question 2. Do Therapy Outcomes Differ Across Ethnic Groups?

Therapy drop-out. A significant relationship was found between ethnic group membership and dropping out of therapy $\chi^2 (4, N = 54397) = 109.33, p < .001$. Percentage drop-out rates across ethnic groups in displayed in Table 5.

Ethnic minority group membership was significantly associated with dropping out of therapy when controlling for age, gender, unemployment and presenting problem severity, $\chi^2 (8) = 1322.54, p < .001$. The variables controlled for were also significantly associated with dropping out of therapy for $\chi^2 (4) = 1270.84, p < .001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.1% of variance in the outcome. Age, gender, unemployment and presenting problem severity explained 3.2% of the variance in outcome. The full regression statistics are available in Table 7.

Table 5

Rates of Acceptance for Therapy, Drop-out, RCSI, Reliable Deterioration and Therapy Frequency Across Ethnic Groups

	Accepted for Therapy (%) (N = 78,076)	Dropped out of therapy (%) (N= 54,397)	No RCSI (%) (N = 28,570)	Reliable Deterioration (%) (N=32,159)	Less than weekly therapy (%) (N = 29969)
Ethnicity					
White	6,456 (9.5)	14,566 (30.4)	8,104 (31.7)	499 (1.7)	10,752 (40.1)
South Asian	362 (10.1)	869 (37.4)	505 (46.1)	35 (2.9)	421 (37.3)
Chinese	65 (12.2)	89 (27.9)	49 (31.2)	1 (0.6)	63 (42.6)
Black	299 (9.1)	839 (37.6)	443 (42.5)	27 (2.3)	410 (36.9)
Other	336 (12.6)	552 (34.7)	294 (40.2)	32 (3.9)	218 (27.9)

Note: No RCSI = Reliable and clinically significant improvement not achieved.

Table 6

Results of Logistic Regression Analysis Predicting Acceptance for Therapy

	Odds Ratio	Lower	Upper	p value
Age	0.99	0.99	0.99	<.001
Gender	1.10	1.05	1.16	.009
Unemployment	1.62	1.52	1.72	<.001
Problem Severity	1.01	1.01	1.01	<.001
S. Asian	1.02	0.91	1.14	.739
Chinese	1.33	1.02	1.73	.034
Black	0.92	0.81	1.04	.171
Other	1.30	1.15	1.46	<.001

Table 7
Results of the Logistic Regression Analysis Predicting Therapy Drop-out

	Odds Ratio	95% Confidence Intervals		p value
		Lower	Upper	
Age	0.98	0.98	0.98	.000
Gender	1.05	1.01	1.09	.009
Unemployment	1.30	1.23	1.37	<.000
Problem Severity	1.03	1.03	1.03	<.000
S. Asian	1.18	1.08	1.28	<.000
Black	1.30	1.19	1.42	<.000
Chinese	0.76	0.59	0.97	.029
Other	1.08	0.98	1.21	.137

Belonging to a South Asian or Black minority group significantly increased the odds of dropping out from therapy. For the South ethnic group, OR = 1.18 (95% CIs, 1.1-1.31), $p < .001$; for the Black ethnic group, OR = 1.30 (95% CIs, 1.21-1.45), $p < .001$. The odds of therapy drop-out were not significantly increased for Chinese or the Other ethnic minority group.

Post therapy change. Psychological outcomes significantly differed according to ethnic group membership, $F(4, 916.26) = 15.26$, $p < .001$. Ethnic minority group membership accounted for significant additional variance in post-therapy psychological change when controlling for age, gender, employment status and initial symptom severity. Adding ethnic groups to the regression model explained an additional 0.6% of the variation in pre-therapy CORE-OM scores. This change in R^2 was significant $\Delta F(4, 32150) = 69.1$, $p < .001$. Age, gender, unemployment and presenting problem severity explained 27.7% of variance, $\Delta F(2, 32154) = 6198.01$, $p < .001$.

Identifying a patient as South Asian, Black and Other was associated with having significantly higher pre-therapy CORE-OM scores. The ‘average’ patient (White, female, employed and 36 years old) would have a reduction of 9 points on their post-therapy CORE-OM score. This compares with the following predicted post-therapy change for patients with equivalent demographic characteristics who were

South Asian (6.9), Black (7.61), or of “Other” ethnicity (7.26). Being of Chinese ethnicity was not significantly associated with lower levels of psychological improvement.

The full regression statistics for post-therapy change are shown in Table 8.

Mean post therapy change across ethnic groups is shown in Figure 2. Group sizes are as follows; White (N = 28799), South Asian (N= 1190), Chinese (N = 166), Black (N = 1181), Other (N = 823).

Reliable and clinically significant improvement. Belonging to an ethnic minority group was significantly associated with failure to achieve RCSI, whilst controlling for age, gender, employment status and presenting problem severity, $\chi^2(8)=1008.06$, $p<001$. The variables controlled for were also significantly associated with failure to achieve RCSI $\chi^2(4) = 119.10$, $p<.001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.5% of variance in the outcome.

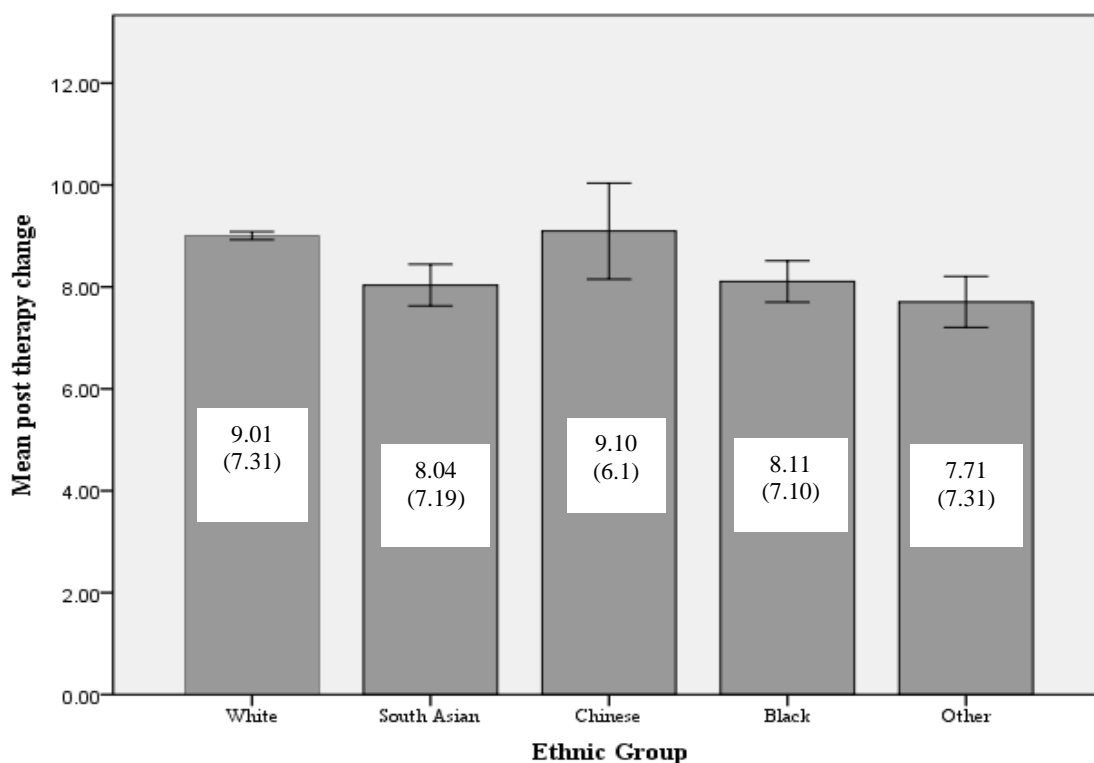


Figure 2. A graph displaying mean post-therapy change across ethnic groups. Standard deviation (SD) and 95% confidence interval bars are also displayed.

Table. 3
Hierarchical Multiple Regression Analyses Predicting Presenting Problem Severity from Ethnic Group Membership

		Coefficients						Model Summary			
		B	SE	Beta	t	95% CI		P value	ΔF (d.f.)	R ²	ΔR ²
						Lower	Upper				
Step 1	Age	-0.016	.002	-.032	-9.087	-0.020	-0.013	<.001	88.385 (2,78959)	.002	.002
	Gender	-0.483	.050	-.034	-9.648	-0.581	-0.385	<.001			
Step 2	Age	-0.041	.002	-.080	-22.223	-0.044	-0.037	<.001	3185.721 (1,78958)	.041	.039
	Gender	-0.594	.049	-.042	-12.099	-0.689	-0.497	<.001			
	Unemployment	3.501	.062	.202	56.442	3.377	3.620	<.001			
Step 3	Age	-0.037	.002	-.072	-20.023	-19.858	-0.033	<.001	87.819 (4,78954)	.045	.004
	Gender	-0.611	.049	-.043	-12.469	-12.462	-0.514	<.001			
	Unemployment	3.474	.062	.201	56.091	56.097	3.593	<.001			
	S. Asian	1.693	.110	.054	15.341	15.375	1.912	<.001			
	Chinese	0.412	.275	.005	1.499	1.526	0.958	.134			
	Black	0.813	.115	.025	7.059	7.094	1.041	<.001			
	Other	1.228	.127	.034	9.691	9.692	1.475	<.001			

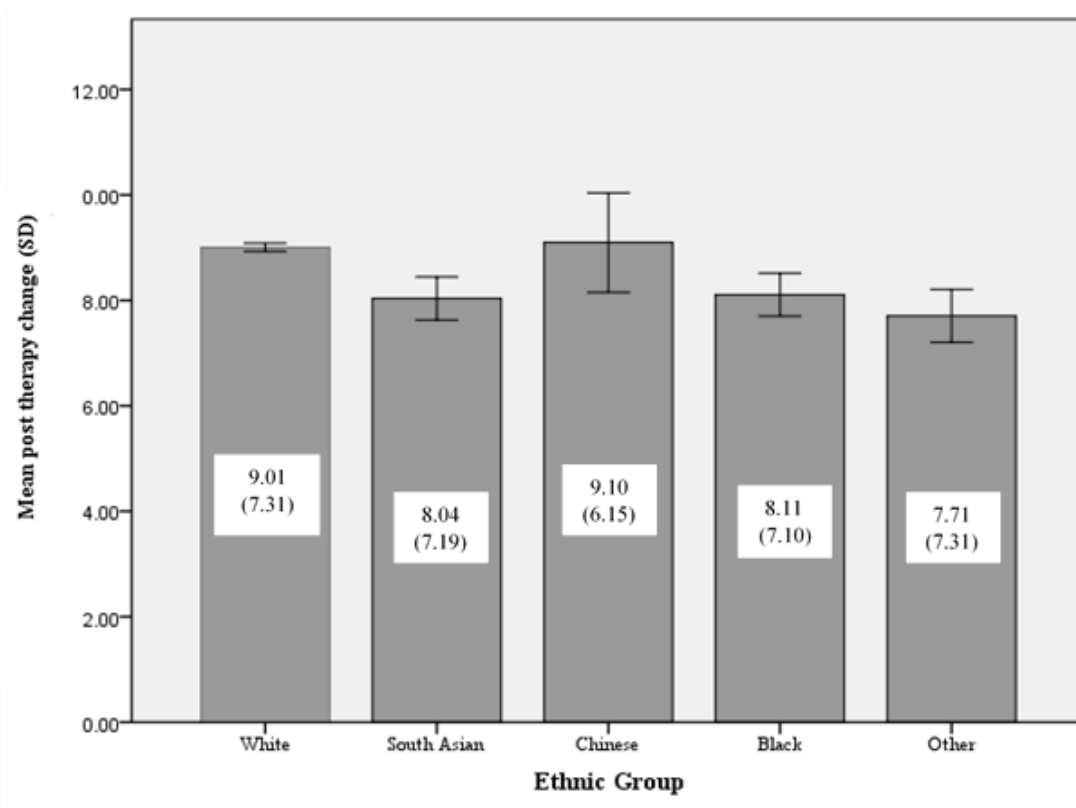


Figure 2. A graph displaying mean post-therapy change across ethnic groups. Standard deviation (SD) and 95% confidence interval bars are also displayed.

Age, gender, unemployment and presenting problem severity explained 4.3% of the variance in outcome.

Belonging to South Asian, Black or 'Other' minority groups significantly increased the odds of failing to achieve RCSI. For the South Asian ethnic group, OR = 1.72 (95% CI, 1.52-1.95), $p < .001$; for the Black ethnic group, OR = 1.53 (95% CI, 1.34-1.73), $p < .001$; for the Other ethnic group, OR = 1.36 (95% CI, 1.17-1.59), $p < .001$. Belonging to the Chinese ethnic minority did not significantly increase the odds of failing to achieve RCSI. The number of patients failing to achieve RCSI, across ethnic groups, is presented in Table 5.

Reliable Deterioration. Ethnic minority membership was also significantly associated with reaching the criteria for post-therapy reliable deterioration, whilst

controlling for age, gender, employment status and presenting problem severity, $\chi^2(8) = 301.61$, $p < .001$. The variables controlled for were also significantly associated with reliable deterioration $\chi^2(4) = 269.06$, $p < .001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.6% of variance in the outcome. In comparison, age, gender, unemployment and presenting problem severity explained 5.6% of the variance in outcome.

Belonging to the South Asian, or ‘Other’ minority group was significantly associated with reliable deterioration at post therapy. For the South Asian patients, OR = 2.06 (95% CI, 1.45-2.92), $p < .001$; for the Other ethnic group, OR = 2.4 (95% CI, 1.66-3.48), $p < .001$. Belonging to Chinese and Black ethnic minority groups was not significantly associated with post-therapy reliable deterioration. The number of patients reaching the criteria for reliable patients, across ethnic groups is shown in Table 5. The full regression tables for RCSI and reliable deterioration are shown in Appendix E.

Question 3: Do therapy processes differ between ethnic groups?

Number and frequency of therapy sessions. The number of therapy sessions attended significantly differed according to ethnic group membership, $F(4, 922.31) = 6.41$, $p < .001$. Chi-square tests showed significant relationship between ethnic group membership and the frequency of sessions $\chi^2(4, N = 29969) = 54.40$, $p < .001$. The frequency of therapy sessions and the mean number of sessions across ethnic groups are shown in Table 5 and Figure 3, respectively.

Number of sessions. Ethnic minority group membership accounted for significant variance in the number of sessions attended when controlling for age, gender and employment status. Adding ethnic groups to the regression model explained an additional 0.1% of the variation in pre-therapy CORE-OM scores. This change in R^2 was significant $\Delta F(4, 32150) = 5.73$, $p < .001$. Age gender, unemployment and

presenting problem severity explained 1.4% of variance, $\Delta F(2, 32154) = 235.61$, $p < .001$.

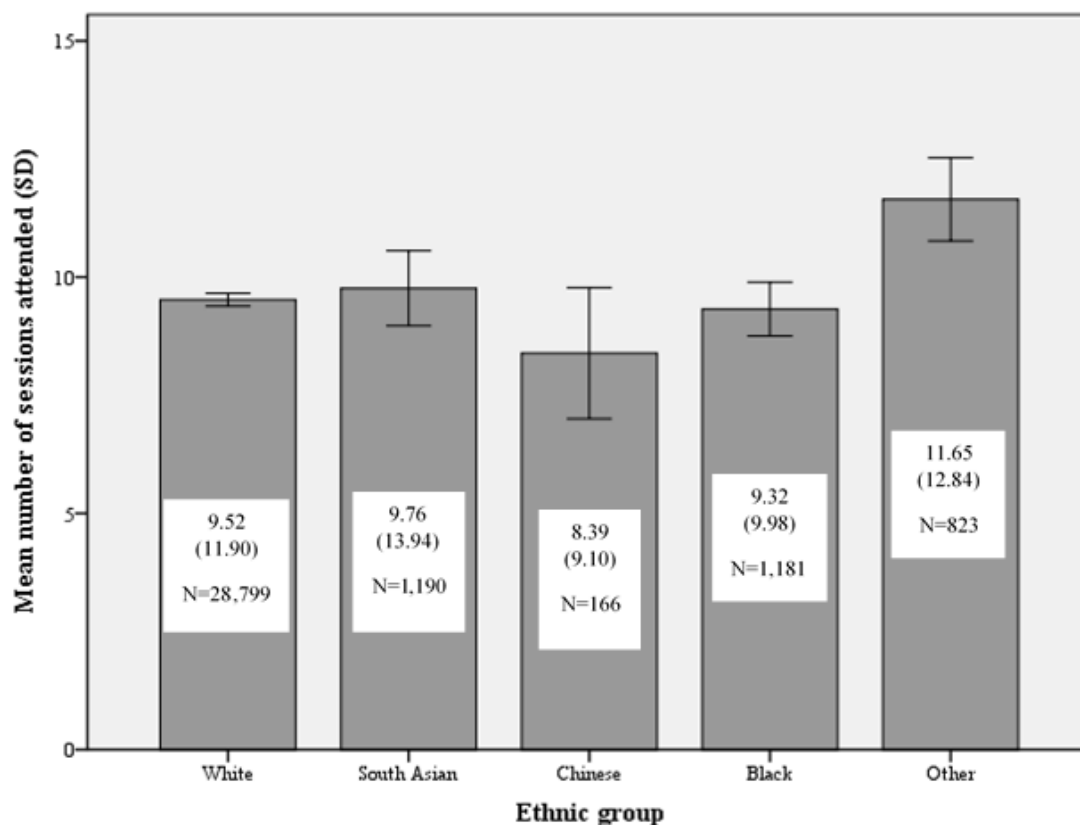


Figure 3. A graph displaying mean number of sessions attended across ethnic groups. Standard deviation (SD), number of patients (N) and 95% confidence interval bars are also displayed.

Belonging to the Other ethnic minority group, was significantly associated with having attended a higher number of sessions. The ‘average’ patient (White, female, employed and 36 years old) attended a predicted 10 sessions. This compares with the prediction that an equivalent patient belonging the Other ethnic minority group would have attended 12 sessions. Being of Chinese, South Asian and Black ethnicity was not significantly associated with a higher number of sessions. The full regression statistics are reported in Table 9.

Frequency of sessions. Ethnic minority group membership was significantly associated with having less frequent (fewer than weekly) therapy sessions whilst controlling for age, gender, employment status and presenting problem severity, $\chi^2(8) =$

536.07, $p < .001$. The variables controlled for were also significantly associated with having less frequent sessions $\chi^2(4) = 496.22$, $p < .001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.2% of variance in the outcome. In comparison, age, gender, unemployment and presenting problem severity explained 2.2% of the variance in outcome.

Belonging to the ethnic minority group Other significantly decreased the odds of having less than weekly sessions, OR = 0.62 (95% CI, 0.53-0.76), $p < .001$. Belonging to a South Asian, Black or Chinese ethnic groups did not significantly influence the odds of having less frequent sessions. The results of the logistic regression are presented in Table 10.

Perceived patient engagement. Chi-square tests showed a significant relationship between ethnic group membership and ratings for all three indicators of engagement: Motivation $\chi^2(4, N = 27543) = 46.80$, $p < .001$; Working Alliance $\chi^2(4, N = 27513) = 52.81$, $p < .001$; and Psychological Mindedness $\chi^2(4, N = 27481) = 68.45$, $p < .001$. Figures 5 to 7 show the number and percentage of ‘medium-poor’ and ‘high’ ratings given by therapists across ethnicities, for all three indicators of engagement.

Patient motivation. Ethnic group membership was significantly associated with being rated as having lower perceived motivation whilst controlling for age, gender, employment status and presenting problem severity, $\chi^2(8) = 412.49$, $p < .001$. The variables controlled for were also significantly associated with lower ratings of motivation $\chi^2(4) = 380.40$, $p < .001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.2% of variance in the outcome.

Table 9
Results of the Hierarchical Linear Regression Analyses Predicting Number of Therapy Sessions According to Ethnic Group Membership

		Coefficients						Model Summary				
		<i>B</i>	<i>SE</i>	Beta	<i>t</i>	lower	upper	<i>p</i> value	ΔF (d.f.)	R^2	ΔR^2	<i>p</i> value
Step 1												
	Age	0.017	0.005	0.018	3.274	0.007	0.027	.001	15.866 (2, 32156)	.001	.001	<.001
	Gender	0.663	0.144	0.026	4.611	0.381	0.945	<.001				
Step 2												
	Age	-0.005	0.005	-0.006	-.973	-0.016	0.005	.331	235.609 (2, 32154)	.015	.014	<.001
	Gender	0.559	0.143	0.022	3.905	0.278	0.839	<.017				
	Unemployment	3.413	0.191	0.103	17.871	3.039	3.788	<.001				
	Pre-therapy score	0.100	0.011	0.053	9.363	0.079	0.120	<.001				
Step 3												
	Age	-0.004	0.005	-0.005	-.795	-0.015	0.006	.427	5.734 (4, 32150)	.016	.001	<.001
	Gender	0.542	0.143	0.021	3.786	0.261	0.822	<.001				
	Unemployment	3.399	0.191	0.103	17.800	3.025	3.774	<.001				
	Pre-therapy score	0.099	0.011	0.052	9.287	0.078	0.120	<.001				
	S. Asian	0.058	0.353	0.001	0.164	-0.634	0.750	.870				
	Chinese	-0.858	0.926	-0.005	-0.926	-2.673	0.958	.355				
	Black	-0.322	0.353	-0.005	-0.911	-1.014	0.371	.362				
	Other	1.921	0.421	0.025	4.564	1.096	2.747	<.001				

Table 10.
Logistic Regression Predicting Frequency of Sessions According to Ethnicity

	Odds Ratio	95% Confidence Intervals		<i>p</i> value
		Lower	Upper	
Age	1.013	1.011	1.015	<.001
Gender	0.746	0.709	0.785	<.001
Unemployment	0.598	0.557	0.641	<.001
Problem Severity	0.997	0.993	1.000	<.075
S. Asian	0.946	0.835	1.096	.382
Chinese	1.196	0.861	0.999	.287
Black	0.892	0.787	1.674	.074
Other	0.624	0.532	0.761	<.001

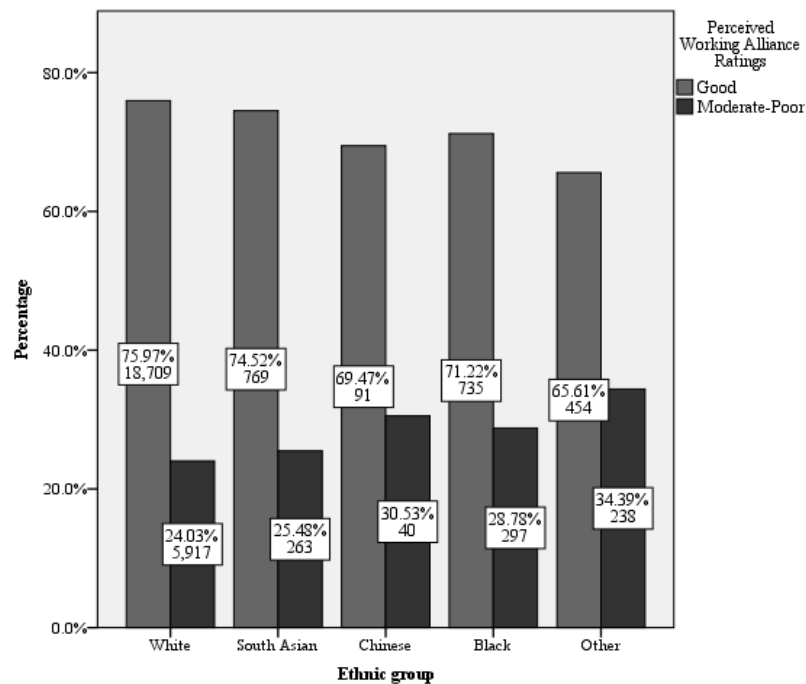


Figure 6. Therapist ratings of psychological mindedness across ethnic groups Percentages and group sizes are shown in the data labels.

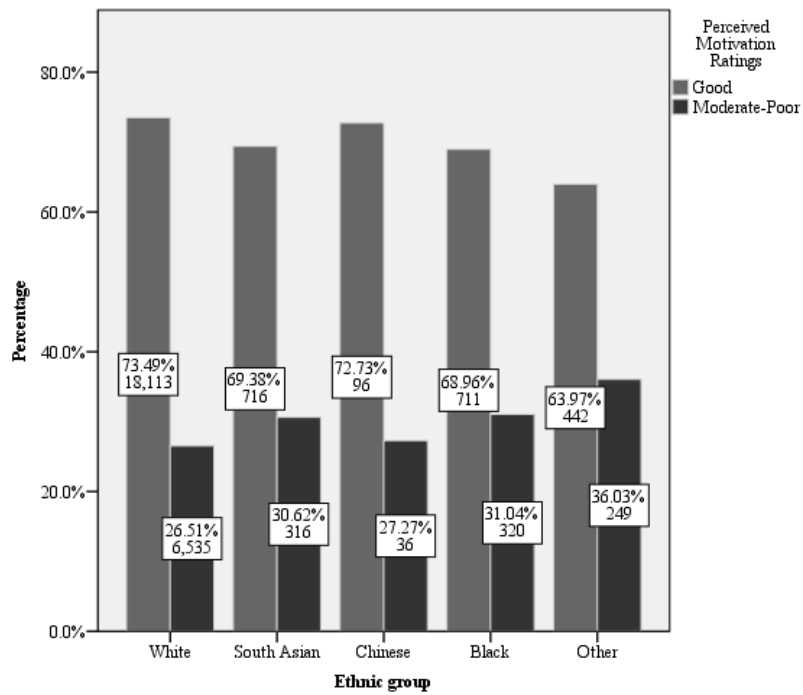


Figure 5. Therapist ratings of patient motivation across ethnic groups.

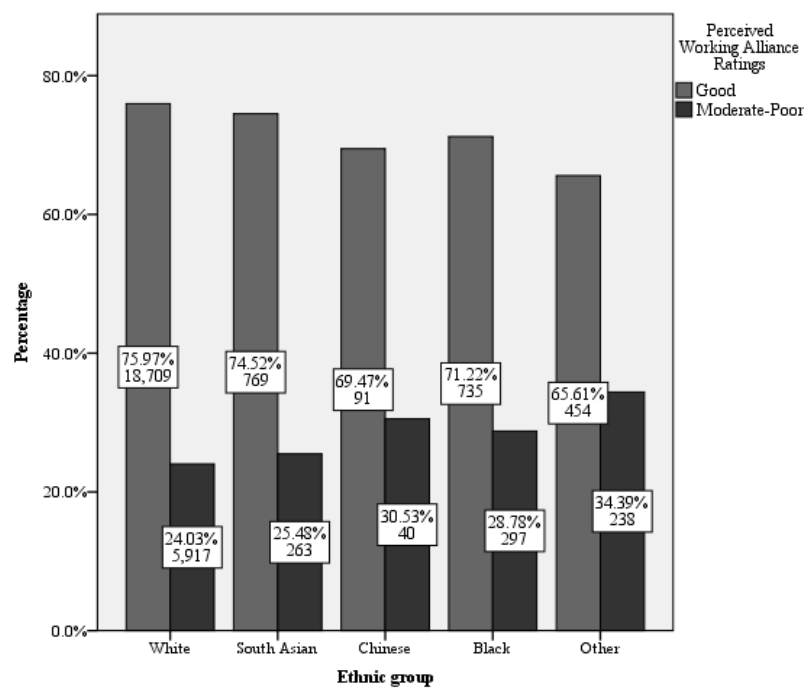


Figure 6. Therapist ratings of working alliance across ethnic groups Percentages and group sizes are shown in the data labels.

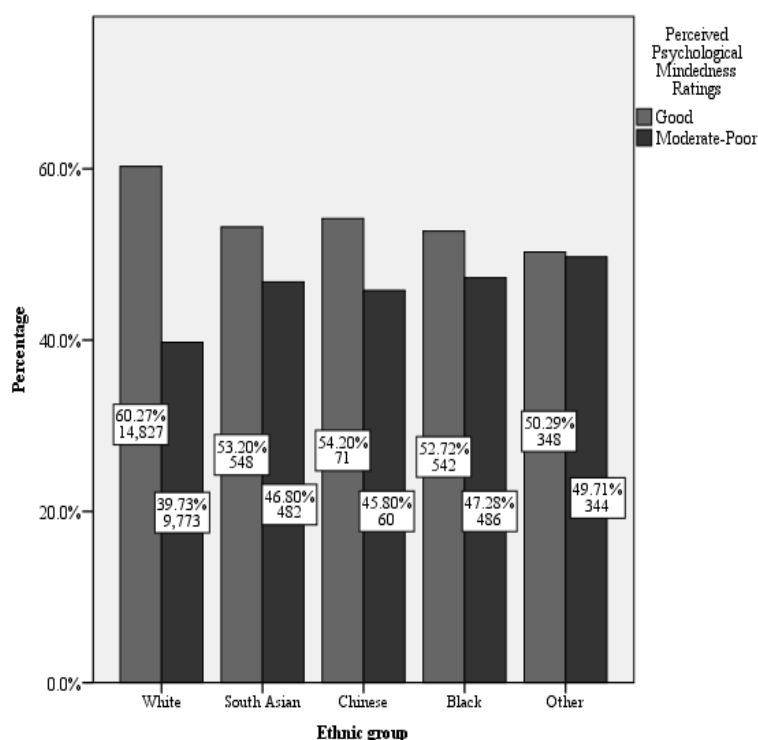


Figure 7. Therapist ratings of psychological mindedness across ethnic groups. Percentages and group sizes are shown in the data labels.

Belonging to the Black, or Other ethnic minority group was significantly associated with lower ratings of motivation. For the Black ethnic group, OR = 1.23 (95%CI, 1.08-1.63), $p=.003$, and for the Other ethnic group OR = 1.56 (95%CI, 1.33-1.83), $p<,.001$. Belonging to Chinese or South Asian ethnic minority groups was not significantly associated with lower ratings of motivation.

Working alliance. Ethnic minority group membership was significantly associated with lower perceived working alliance whilst controlling for age, gender, employment status and presenting problem severity, $\chi^2(8) = 341.92$, $p<0.001$. The variables controlled for were also significantly associated with lower ratings of working alliance $\chi^2(4) = 302.01$, $p<,.001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.2% of variance in the outcome. Age, gender, unemployment and presenting problem severity explained 1.6% of the variance in outcome.

Belonging to the Black, or 'Other' ethnic minority group was significantly associated with lower ratings of working alliance; for the Black ethnic group, OR = 1.23 (95%CI, 1.10-1.46), $p=.001$; for the Other ethnic group, OR = 1.56 (CI=1.33-1.83), $p<,.001$. Belonging to Chinese or South Asian ethnic minority groups was not significantly associated with lower ratings of working alliance

Psychological mindedness. Ethnic minority group membership was significantly associated with lower perceived psychological mindedness whilst controlling for age, gender, employment status and presenting problem severity, $\chi^2(8) = 664.98$, $p<001$; The variables controlled for were also significantly associated with having lower ratings of psychological mindedness $\chi^2(4) = 611.03$, $p<.001$. The Nagelkerke R Square value indicated that ethnicity accounted for an additional 0.2% of variance in the outcome. Age, gender, unemployment and presenting problem severity explained 3% of the variance in outcome.

Belonging to the South Asian, Black, or Other' ethnic minority group was significantly associated with lower ratings of perceived psychological mindedness; for the South Asian ethnic group, OR = 1.28 (95%C, 1.12-1.45), $p=.001$; for the Black ethnic group, OR = 1.36 (95%CI, 1.20-1.54), $p=.001$; and for the Other ethnic group, OR = 1.42 (95%CI, 1.22-1.65), $p<,.001$. Belonging to the Chinese ethnic group was not significantly associated with lower ratings of psychological mindedness.

The results of the logistic regression analyses for perceived patient motivation, working alliance and psychological mindedness across ethnic groups are displayed in Table 11.

Table 11.
Logistic Regression Analysis for Perceived Patient Motivation, Working Alliance and Psychological Mindedness According to Ethnicity

		Odds Ratio	95% Confidence Intervals		p value
			Lower	Upper	
Motivation	Age	0.994	0.991	0.996	<.001
	Gender	1.255	1.186	1.329	<.001
	Unemployment	1.629	1.515	1.751	<.001
	Problem Severity	1.019	1.015	1.023	<.001
	S. Asian	1.153	1.005	1.358	.042
	Chinese	1.027	0.698	1.478	.893
	Black	1.231	1.075	1.628	.003
	Other	1.466	1.250	1.720	<.001
Working Alliance	Age	0.994	.992	.996	.001
	Gender	1.312	1.237	1.390	<.001
	Unemployment	1.562	1.450	1.683	<.001
	Problem Severity	1.013	1.005	1.017	<.001
	S. Asian	1.030	0.891	1.190	.691
	Chinese	1.367	0.940	1.989	.102
	Black	1.269	1.104	1.458	.001
	Other	1.561	1.329	1.833	<.001
Psychological Mindedness	Age	0.998	0.996	1.001	<.014
	Gender	1.375	1.305	1.454	<.001
	Unemployment	1.718	1.604	1.841	<.001
	Problem Severity	1.023	1.019	1.027	<.001
	S. Asian	1.276	1.124	1.448	<.001
	Black	1.304	0.921	1.845	<.001
	Chinese	1.358	1.197	1.541	.134
	Other	1.419	1.218	1.654	<.001

Question 4: Are BME Service Users More Likely to Access NHS or non-NHS Services?

Ethnic minority group membership was significantly associated with seeking help from a non-NHS service $\chi^2 (8) = 9636.51, p < .001$; whilst controlling for age, gender, unemployment and presenting problem severity. All ethnic minority groups included had significantly lower odds of accessing NHS services; for South Asian, OR = 0.50 (95% CI, 0.46-0.55), $p < .001$; Chinese, OR = 0.23 (95% CI, 0.17-0.31), $p < .001$; Black, OR = 0.24 (95% CI, 0.22-0.27), $p < .001$; and Other OR = .50 (95% CI, 0.46-.55), $p < .001$. Figure 6 shows the proportion of patients from each ethnic group seeking help across the NHS (primary, secondary and tertiary) and non-NHS (university, workplace, voluntary and private) services.

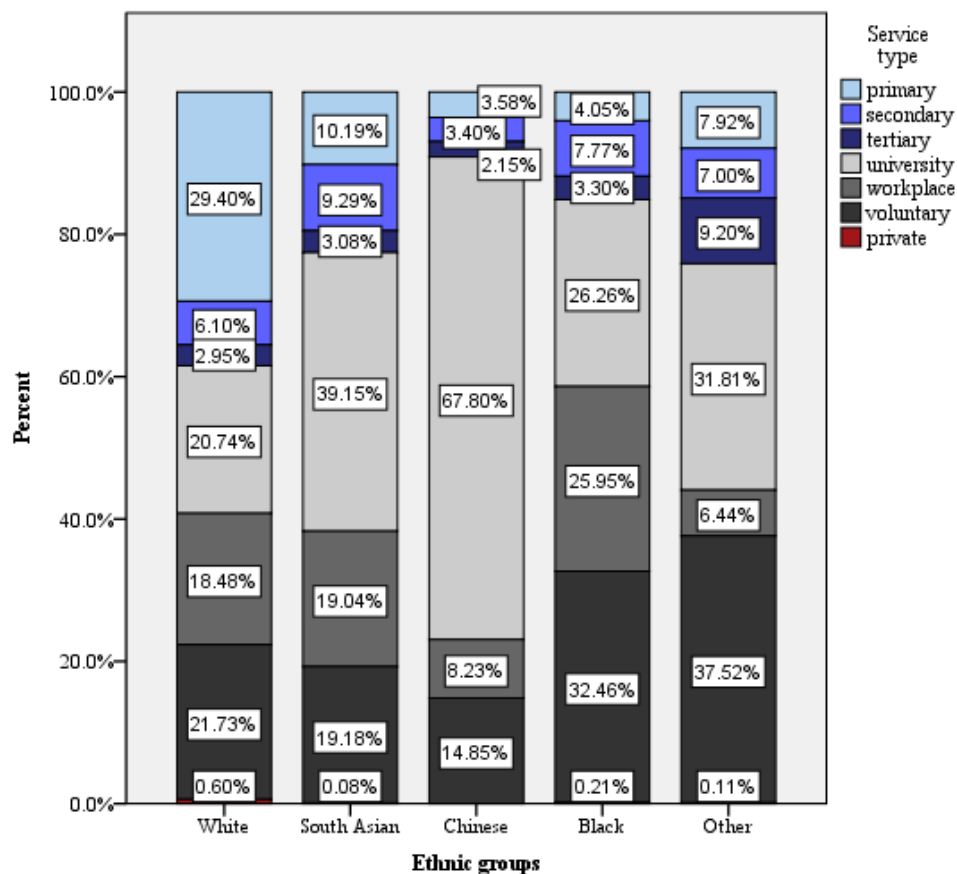


Figure 8. A graph showing the proportion of patients from each ethnic group seeking help from NHS and Non-NHS services

Discussion

Summary of Main Findings

The results of this study provide evidence for the presence of ethnic inequalities occurring within psychological services in the UK between 2006 and 2011. The results suggest that there are significant differences between service users from White ethnic groups, in comparison to, Black, Asian and Other ethnic minority groups. Differences occurred at therapy intake, across therapy processes, and across psychological outcomes. Differences remained significant whilst controlling for confounding variables of age, gender, unemployment and presenting problem severity. The Chinese ethnic minority group did not significantly differ from the White group. However, this was based on a relatively small sample of Chinese patients, mostly presenting to university services. The study also found that all BME patients were significantly more likely to have attended non-NHS services to seek help.

Ethnic Variation at Therapy Intake

Presenting problem severity. Black, Asian and Other ethnic minority patient groups presented to services with significantly higher levels of distress, as measured by the CORE-OM. Presenting to services with higher levels of distress suggests a pattern of delayed help seeking, consistent with previous literature (Bhui et al., 2003). The current findings do not provide any explanation for this finding. However, the help seeking patterns observed across NHS versus non-NHS services highlight potential explanations based on previous literature.

The current findings suggest that people from BME backgrounds may find it more acceptable to seek early help from non-NHS services. Voluntary, university and workplace services are likely to offer support for mild-moderate levels of emotional distress, similar to the remit of care provided by primary care NHS services. Within this

study, a relatively low proportion of ethnic minority patients, have accessed primary care psychological services, for mild-moderate difficulties. Notably, a much higher proportion accessed non-NHS services (university, voluntary and workplace), presumably also for mild-moderate difficulties. This suggests it may not be the act of seeking early help per se that is problematic for people from BME backgrounds but rather the context in which help is sought.

Previous literature cites three main reasons for delayed help seeking in BME communities; awareness of services, negative perception of services, and a lack of culture-specific resources/skills (e.g. interpreters, translated information and understanding of religious/spiritual/cultural beliefs and values; MIND, 2013). It is possible that services based in universities, workplaces and within the local community may be more visible to BME communities. In addition, such services may be more likely to provide counselling and less likely to use diagnostic language, possibly reducing fears of problems being pathologised (Anthony, 2015). For people who are more likely to feel a sense of shame for requiring psychological support, it may feel easier to see a workplace or university based counsellor for issues around ‘stress’ than to attend the GP surgery, be diagnosed with anxiety and referred to psychological therapy. This view is supported within previous literature. Actively publicising mental health services within BME communities, allowing self-referral, and using terms such as wellbeing instead of mental health, have successfully increased access rates of BME service users to primary care psychological services (Clark et al., 2009).

Acceptance for therapy. The results suggest ethnicity may impact on the rate at which service users are accepted for a course of therapy following an assessment. This difference was only found for the Other minority ethnic group. From the current data it is not possible to determine the specific ethnicities included in the Other ethnic

minority group. According to the Office for National Statistics (ONS; 2005), the “Other” ethnic group most commonly comprises people identifying as having mixed ethnicities, people from the Far East (Philippines, Japan, Thailand and Vietnam), and people identifying as Arab (ONS, 2005). Patients within this category were significantly less likely to be offered a course of therapy following assessment, with an OR of 1.3. This suggests that people from some ethnic minority groups may be disproportionately rejected from psychological services despite being willing to seek help.

Lack of qualitative data surrounding these decisions means determining the underlying cause for this is beyond the scope of the current research. Speculatively, it is possible that factors previously cited within the literature may have contributed to this finding. Firstly, people within the Other ethnic group may have been less likely to have English as their first language, therefore provision of therapy may have been dependent on the availability and acceptability of using interpreters. Secondly, the provision of therapy may have been deemed unsuitable in cases where clients’ expressions of distress were influenced by culture and perhaps misinterpreted or misunderstood by the assessing therapist (Bhui et al., 2015).

Ethnic Variation Across Therapy Outcomes and Processes

Therapy outcomes. The findings indicated that patients from South Asian, Black and Other ethnic groups had significantly poorer psychological outcomes following therapy, in comparison with patients of White ethnicity. South Asian and Black patient groups were significantly more likely to drop out of therapy. South Asian, Black and Other minority ethnic patients were significantly less likely to achieve reliable and clinically significant improvement. Additionally, South Asian and Other ethnic minority patients were more likely to deteriorate over the course of therapy.

Increased rates of treatment drop-out for ethnic minority patients have been established across mental health services and within psychological therapy treatment trials (O'Brien et al., 2009; Rathod et al., 2005). However, the literature using routinely collected data from psychological services has been less consistent. Saxon, Barkham, Foster and Parry (2016) found that belonging to a 'non-white' ethnic group did not significantly predict therapy drop-out or deterioration, but that therapist effect did. This could suggest that when therapist effects are accounted for, the significance of ethnicity may be diminished. Although, the current study utilised a larger data set and examined differences across specific ethnic groups which may also explain the difference in findings.

Poorer psychological outcomes for South Asian, Black and Other ethnic minority groups suggests that ethnicity may have impacted upon the efficacy of the treatment provided. South Asian and Black ethnic groups using mental health services in the UK have reported feeling higher levels of dissatisfaction with their treatment (Agoro, 2014; MIND, 2013). However, UK based empirical evidence into psychological outcomes, according to ethnicity, has been inconsistent and relatively sparse. These findings provide preliminary evidence that outcomes for people of BME backgrounds may not be equal to that of their White counterparts. These findings are limited by the design of the study as naturally occurring practice based data does not allow complete control over confounding variables. It is possible that factors, not controlled for within the current study accounted for differences in psychological outcomes for BME patients.

Therapist effects were not controlled for within the current study and have been found to link to post-therapy outcomes (Saxon et al., 2016). However, ethnicity effects and therapist effects are not likely to be mutually exclusive, it is possible that some therapists have more successful outcomes with BME clients. Several therapist factors

have been found to increase cultural responsiveness and the effectiveness of psychological interventions for BME clients; ethnic matching, cultural competency training, culturally responsive clinical supervision and experience working with ethnic minority clients (Afuwape et al., 2010; Chowdhary et al., 2014). It is possible that within non-NHS services, where the higher proportions of BME clients were seen, therapist skills and qualifications may have been lower, contributing to poorer outcomes.

Therapy processes. The current findings indicate that patients from Black and Other ethnic minority backgrounds were perceived by therapists as less motivated with a weaker working alliance between therapist and client. Additionally, South Asian, Black, and Other ethnic groups had significantly lower ratings of psychological mindedness. These findings may shed further light on therapist, client, cultural and societal factors that may have influenced perceived engagement with therapy and subsequent psychological outcomes.

A therapist factor that may influence engagement with some BME clients is the ability to demonstrate cultural responsiveness. Psychological treatment that explicitly integrates culture into the intervention has been found to be effective for BME clients, and in some cases more effective than standard treatment approaches (Benish et al., 2011; Chowdhary et al. 2014;). Failure to adequately respond to cultural diversity may have led to poorer engagement and poorer outcomes for individuals from BME backgrounds.

The literature also refers to patient factors such as mistrust and ambivalence existing amongst some Black and South Asian communities, as services are perceived as culturally insensitive, coercive and oppressive (Keating et al., 2002). If patients from BME backgrounds were more likely to have negative perceptions about the intentions of their therapist, this may have negatively impacted upon the therapeutic relationship.

Therapist rejection is particularly likely if clients feel their therapist has not understood the influence of culture on their lives (Bhui & Morgan, 2007).

Cultural factors may also influence patient perception of therapy and acceptable expressions of distress. Lowe (2010) suggests that expressions of ambivalence by Black people in therapy may defend against inward feelings of vulnerability. People from black communities may express more reluctance to reveal their vulnerability due to the historical and social position of psychological services being equated with White control (Lowe, 2010). Cultural expectations to remain “strong” may also reinforce these barriers and impact on the process of engaging with therapy and the therapist (Myrie & Gannon, 2013). BME patients may also be more likely to hold explanatory models of mental illness which are different to that held by their therapists. Favouring Eurocentric models of psychological problems may mean that therapists deem their patients to lack psychological mindedness if they do not adhere to the same explanatory frameworks (Alreja et al., 2009).

In regard to social factors, patients from ethnic minority backgrounds are more likely to live with multiple disadvantages and have experienced racism and discrimination (Singh et al., 2014). The impact of these external factors may influence engagement with the therapeutic processes and limit motivation, particularly if issues of injustice are not adequately considered by therapists.

The findings indicated that across all but one ethnic group (Other) the number and frequency of sessions delivered did not significantly differ. This suggests that the differences in outcomes and engagement between ethnic groups, was not due to a different level of service provision. Patients from the Other minority ethnic group were found to have significantly more sessions, more frequently. Reasons for this are unclear. However, it is of interest that the increase in sessions did not result in better outcomes for this group. It is possible that service provision differed due to increased

complexity within this client group. Additionally, the highest proportion of the Other ethnic group (37.5%) attended voluntary sector services which may have increased the flexibility of service provision. Therapists may have taken on dual roles of providing a therapeutic relationship alongside practical support with issues such as housing, benefits and employment, requiring an increased level of support.

Strengths and Limitations

The current study has several strengths. Firstly, differences between ethnic groups were explored at several time points across engagement with psychological services, allowing for increased understanding of ethnic inequalities occurring within psychological services. A variety of outcomes were examined from both self-report and therapist rated variables. Secondly, differences were found whilst controlling for confounding variables; age, gender, unemployment and presenting problem severity. Lastly, the data used included relatively large numbers of patients from ethnic minority backgrounds allowing for the separation of ethnic minority groups, South Asian, Black, Chinese and Other.

The results of the current findings should also be interpreted with knowledge of the study's limitations. Previous literature suggests that ethnic variation across mental health services can be explained by markers of social and economic disadvantage disproportionately affecting BME communities (Singh et al., 2014). Unemployment was controlled for as a marker of socioeconomic status, however, other potentially relevant variables, such as welfare difficulties and living circumstances, were not. It is possible that including these variables may have diminished the differences found between ethnic minority groups and the White group.

The measurement tool used to define psychological distress and change may also have influenced the difference found across ethnic minority groups. The validation of the CORE-OM has been completed with majority White British samples. There is no

known validation of the CORE-OM within different ethnically diverse groups meaning that the clinical cut off points, and the index of reliable and clinically significant change may be different within ethnic minority groups. However, this does not necessarily undermine the conclusions drawn from the current study. The CORE-OM was specifically designed to be an accessible and versatile measurement tool for use across a variety of patients. The development of the CORE-OM included consultation with professionals and service users from ethnic minority backgrounds. Issues of differences in language and culture, and how they may influence the interpretation and endorsement of items on the CORE-OM were explicitly considered and addressed during the development of the tool (Barkham et al., 2001). It is therefore possible that whilst the normative data for this CORE-OM could differ within ethnic minority groups, this may reflect higher levels of actual distress and should not necessarily be considered as measurement error.

Differences across services may also have influenced the results and confounded the findings. The services included in the study were anonymised, meaning that the availability of service related data was limited. It is possible that other service related variables may have influenced some of the outcomes examined. For example, services within certain geographical locations would be more likely to be affected by higher levels of social and economic disadvantage. This may have restricted the number of patients they accept and the number of sessions they provide. It is also likely the people from ethnic minority backgrounds are overrepresented in disadvantaged areas (Singh et al., 2014). Additionally, services offering a specific therapy type may offer a set number of sessions based on the evidence from clinical guidelines. In future research, collecting data concerning the geographical location of the service, and details which may constrain service delivery, will be important to overcome this limitation.

Another limitation of the study is the use of only four ethnic minority group categories. The Black and South Asian ethnic groups included people from a range of ethnic sub-groups and the specific ethnic make-up of the Other ethnic minority group was unknown. There is likely to be a high level of diversity amongst the ethnic groups detailed in the current study, limiting the specificity of the conclusions drawn from the data. Arguably, however, the distinction between four ethnic groups still highlighted important differences between ethnic minority groups and further supports the importance of considering ethnic minority groups separately when examining differences between BME and White groups.

Clinical Implications

The current findings suggest that belonging to an ethnic minority group may be associated with delayed help seeking, poorer therapy outcomes and poorer perceived engagement. Psychological services should be committed to delivering equitable services, inequalities should therefore be identified and addressed.

In order for inequalities to be identified patient demographic data needs to be collected along with details of patient pathways to, and through, services. Data needs to include the outcomes of psychological therapy interventions. Regularly conducted audits and service evaluations would also ensure the collation of patient data and identification of ethnicity related differences. The collection of qualitative data would provide further insight into differences occurring across ethnic groups, and could be locally collected from service users or community groups.

The cultural responsiveness of services could be increased by ensuring the professionals leading and delivering services are aware of the issues affecting people within the community they are based. This includes knowledge of local ethnic minority communities and assessment of whether they are accessing the services at a proportionate rate and achieving equal outcomes. Engaging in dialogue with

community leaders and organisations may serve to publicise services and increase awareness of issues impacting upon some BME communities.

Individual therapists should commit to developing their own cultural responsiveness. It should be recognised that an individual from BME backgrounds may have had different experiences and hold different perceptions of therapy in comparison to patients from White backgrounds. Clinicians collecting data around ethnicity could use this as an opportunity to engage in a conversation around a client's ethnic identity, how this relates to their cultural beliefs and expectations, and how that may have an influence on therapeutic processes. Addressing these issues during the assessment phase would allow for cultural responsiveness to be demonstrated throughout the treatment process and may prevent disengagement arising from feelings of being misunderstood.

The current study has utilised data from 1999 to 2011. The ethnic make-up of the UK is dynamic, as are the cultural issues impacting upon some ethnic minority groups. For example, the Black Lives Matters movement originating in North America has had a huge impact on Black communities in the UK, observable through evolving rhetoric around social injustice, increased activism and refusal to accept the disadvantages Black people face in the hands of 'White' institutions (Garcia & Sharif, 2015). As awareness of the inequalities occurring in mental health care grows, so could mistrust of associated services. Policy, services and individual clinicians should be aware of the presence and impact of social and political contexts which may be particularly salient for people from BME backgrounds.

Future research efforts should focus on three main areas. Firstly, services should continue to collect, analyse and disseminate findings from practice based data to identify and address service specific ethnic inequalities. Secondly, controlled clinical trials of psychotherapy approaches should actively seek participants from a diverse

range of ethnic backgrounds. This would enable us to identify the effect of ethnic group membership on psychological outcomes within a more controlled context. Thirdly, institutions training therapists and psychologists should attempt to redress the balance of teaching and adopting Eurocentric models of psychological therapies. Such approaches should not be ‘alternative’ approaches but embedded into mainstream curriculums in order to broaden psychological conceptualisation of distress and methods of treatment.

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Appendix A: Letter of Ethnical Approval



Health Research Authority

NRES Committee Yorkshire & The Humber - Leeds East

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24 February 2014

Professor Michael Barkham
Professor of Clinical and Counselling Psychology
University of Sheffield
Centre for Psychological Services Research
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Dear Professor Barkham

Study title: An evaluation of the effectiveness of the psychological therapies as delivered in routine practice settings within primary and NHS service settings.
REC reference: 05/Q1206/128
Amendment number: Amendment 3, 05/02/14
Amendment date: 05 February 2014

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

It was noted that data had been gathered for some time, and clarification was requested as to whether the researchers had, or intended to, disseminate any interim results to participants.

You replied that because the dataset is anonymised, you cannot, de facto, disseminate interim results to participants. You had published extensively on the dataset such that the yield is in the scientific and public domain. Accordingly, you had disseminated findings in the way you envisaged but it would never have been possible to direct these to participants due to anonymity. You added that you could provide a listing of these publications if that would be of assistance to the Committee in arriving at a decision.

In addition to this, it was questioned whether the researchers were still anticipating using their previous plans for dissemination with this current data set, or if they had any new plans as the additional data set would be quite considerable.

You responded that because the dataset was anonymised at the level of the individual participant and the organisation (other than type of organisation), the same restrictions would apply in that you cannot feedback directly to participants at any level. However, the key difference in the additional data set was that the sectors from which the data was drawn, was broader. In that sense, it therefore enabled you to make comparisons between organisational sectors that were not possible in the earlier data set. Hence, while the data set is large in terms

of the total number of participants, when it was clustered according to the differing types of organisations (i.e., NHS [primary, secondary, tertiary], voluntary sector, university counselling, workplace counselling), then the number of participants within each type was considerably reduced. It was this diversity of organisational type that was the rationale for the current data set. In light of this, your dissemination plans would target learned journals and conference presentations focusing on organisational components.

You went on to say that an initial focus would be on the voluntary sector (VS) services as there is a paucity of research relating to this sector. Although the organisations in the data set are anonymous, you were planning on contacting local VS services to report on data from these analyses in order to provide them with the evidence arising from the data. Hence, there would be a direct means of dissemination to this sector. In other words, building a link between the yield of the data and 'real' organisations in the community, which might encourage them to collect and use data in support of their services. In this sense, the dissemination strategy was different as it could focus on organisational type in a way that the previous data sets did not.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMPs)	Amendment 3, 05/02/14	05 February 2014

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

05/Q1206/128:	Please quote this number on all correspondence
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Yours sincerely



pp
Mrs Alison Barraclough
Chair

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Appendix B: CORE-OM

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Appendix C: CORE Therapy Assessment Form

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Appendix D: Core End of Therapy Form

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Appendix E: Logistic Regression Table

Table A1
Logistic Regression Analysis for RCSI and Reliable Deterioration According to Ethnicity

		95% Confidence Intervals			<i>p</i> value
		Odds Ratio	Lower	Upper	
RCSI	Age	1.001	.999	1.003	.310
	Gender	1.118	1.059	1.180	<.001
	Unemployment	1.560	1.458	1.670	<.001
	Problem Severity	1.058	1.053	1.063	<.001
	S. Asian	1.723	1.521	1.951	<.001
	Chinese	1.055	0.749	1.487	.759
	Black	1.525	1.342	1.733	<.001
	Other	1.360	1.167	1.585	<.001
Reliable Deterioration	Age	0.998	0.992	1.005	.563
	Gender	1.082	0.912	1.285	<.336
	Unemployment	1.840	1.485	2.281	<.001
	Problem Severity	0.898	0.886	0.910	<.001
	S. Asian	2.056	1.445	2.927	<.001
	Chinese	0.376	0.052	2.698	.330
	Black	1.393	0.939	2.068	.100
	Other	2.400	1.658	3.474	<.001

Note: RCSI = Reliable and Clinically Significant Improvement.